



# *The Modern Hospital*

**DECEMBER 1949**

*The job for federal hospitals • Clinics by  
television • The degree doesn't make the nurse • Formula  
unit on display • Beauty shop for mental patients • Hospitals  
around the world • Plan for an emergency department*

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electrical and air conditioning  
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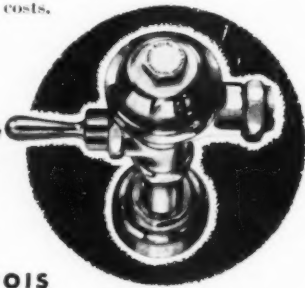
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# The Modern Hospital

DECEMBER 1949

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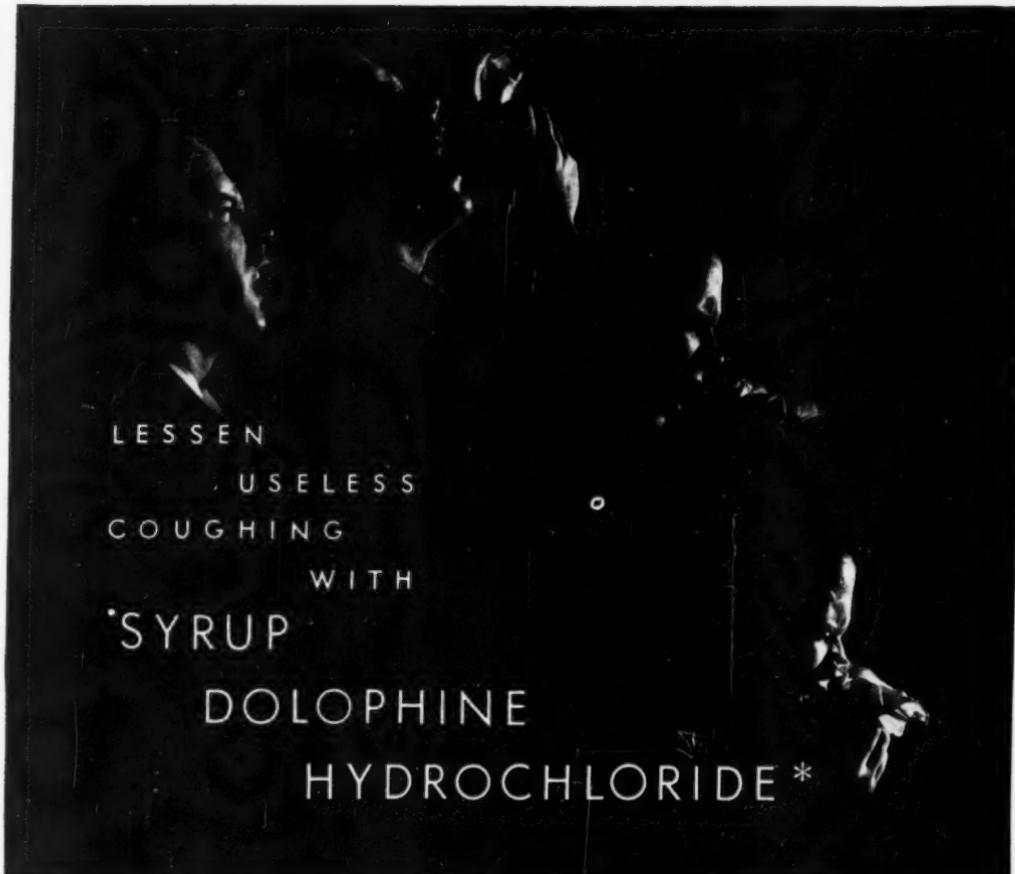
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## AMONG THE AUTHORS

**J. Milo Anderson**, who comes up with a strong defense of hospital nursing schools on page 59 of this magazine, is administrator of the Methodist Hospital at Gary, Ind. Mr. Anderson went to Gary four years ago after serving for several years as assistant superintendent of the University of Chicago Clinics. A graduate of St. Olaf College at Northfield, Minn., he has a master's degree in hospital administration from the University of Chicago. While at the university clinics Mr. Anderson was active in the affairs of the Chicago Hospital Council and the Illinois Hospital Association. When he moved to Gary, these interests were transferred to the Indiana Hospital Association, which he is now serving as president.



J. Milo Anderson

**Grace F. McConnell**, whose article about a therapy program for mental patients appears on page 63, brings an unusual perspective to her subject: She is a psychiatric aide at the Napa State Hospital, Imola, Calif., where she was also a patient several years ago. Mrs. McConnell is the daughter of a California physician. She is a graduate of Dominican College at San Rafael, Calif., and has been a school teacher and business woman as well as a writer. Following her own illness and hospitalization she decided to enter the hospital field. "I have never regretted the decision," she writes. "I am happy to be working here as a psychiatric aide in the same hospital where I was treated and cured of my own illness."

**Alfred E. Maffly** is administrator of Herrick Memorial Hospital at Berkeley, Calif. Following graduation from the University of California in the school of business administration in 1921, Mr. Maffly had 10 years' experience in business as an accountant, then entered teaching and school administration. In 1933, he became administrator of the Berkeley Hospital, which under his direction was changed into a non-profit corporation and renamed to honor Dr. Francis L. Herrick, who founded the hospital in 1904. Mr. Maffly is a fellow of the American College of Hospital Administrators; a past president of the East Bay Hospital Conference, and a delegate from California to the American Hospital Association. He is a lecturer in the school of public health at the University of California and course coordinator for the program in hospital administration there.



A. E. Maffly

**Henry X. Jackson**, assistant administrator and executive officer of the Herrick Memorial Hospital in Berkeley, has just been selected to be the first administrator of the new Marin General Hospital, now in the planning stage at Greenbrae, Calif. Mr. Jackson received the master in hospital administration degree from Northwestern University following an administrative residency at Herrick Memorial Hospital. He also received a bachelor's degree in economics from Northwestern. During the war, he was a supply corps officer in the United States Navy. Mr. Jackson is a nominee of the American College of Hospital Administrators. He is a visiting lecturer in the course in hospital administration at the University of California. Mr. Jackson and Mr. Maffly have collaborated in the preparation of an article describing the new emergency service at Herrick Memorial. The article appears on page 54.



H. X. Jackson

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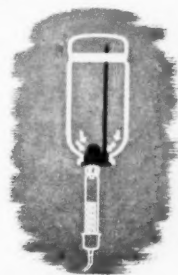
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# Roving Reporter

## For That Family Feeling

Nothing promotes that family feeling more than sitting down at holiday dinner together. Dr. Warren F. Cook, executive director of New England Deaconess Hospital, Boston, can testify to this.

Each Thanksgiving and Christmas all employees are invited to be guests of the hospital for dinner. Extra dinner tickets can be purchased for \$1.50 per person. Last year 163 members of this hospital's family took Thanksgiving dinner at the hospital; on Christmas there were 127 acceptances to the invitation.

## Blood Bank Campaign

Cheery as a Christmas card in its bright red cover and red bordered interior is Rhode Island Hospital's folder "This Patient Needs Blood."

Opening sentence is this: "When the doctor says, 'This patient needs blood,' he's looking at YOU." It continues its appeal to healthy persons with the statement that the blood bank is one of the hospital's most important community services. In this bank, it relates, many pints of human blood are deposited in preparation for all emergencies.

"Remember, too," says the message to volunteers and prospective volunteers, "that we give thousands of pints of blood yearly to patients who have no

social service departments, the blood bank itself, and at the main information desk. Copies also are available to members of the staff who care to use them.

A red wallet sized "Thank You" card with the donor's name, date of his contribution, and blood type is mailed out as soon after the donation as the blood type has been determined.

Other promotion materials are going out from the blood service. The speakers' bureau talks on the bank; a letter has been sent to all radio stations telling why donors are needed; a questionnaire for the use of interns and others taking information from patients' families listing clubs, churches and unions to which the patient in debt to the bank may belong is later used by the director of the blood service in asking assistance for the patient.

## Silent Servant for Employees

It was all a big surprise to the employees of the 16 hospitals operated in Wisconsin, Illinois, Missouri and Louisiana by the Hospital Sisters of the Third Order of St. Francis, Springfield, Ill., when recently a personnel booklet was passed out to each of them. For the first time they had it down in black and white just what was expected of them in their work and in their attitudes, and they learned the answers to questions that had puzzled them.

The Hospital Sisters of the Third Order were clever enough to individualize the booklets to the extent that nursing personnel received one type of guide book and the nonprofessional employees received another. Moreover, each of the 16 hospitals had an imposing photograph or architectural drawing of its own building on the cover.

Said Mother Magdalene, O.S.F., provincial of the motherhouse: "This convenient little brochure has been prepared to serve as an ever ready, silent servant to answer many questions that arise during the busy work day and to help acquaint the employees with their environment. It explains the rules and regulations that have grown out of the policies formulated by the Hospital Sisters of the Third Order of St. Francis throughout the years to create and maintain harmonious personnel relationship in the important work of caring for the poor and the sick."



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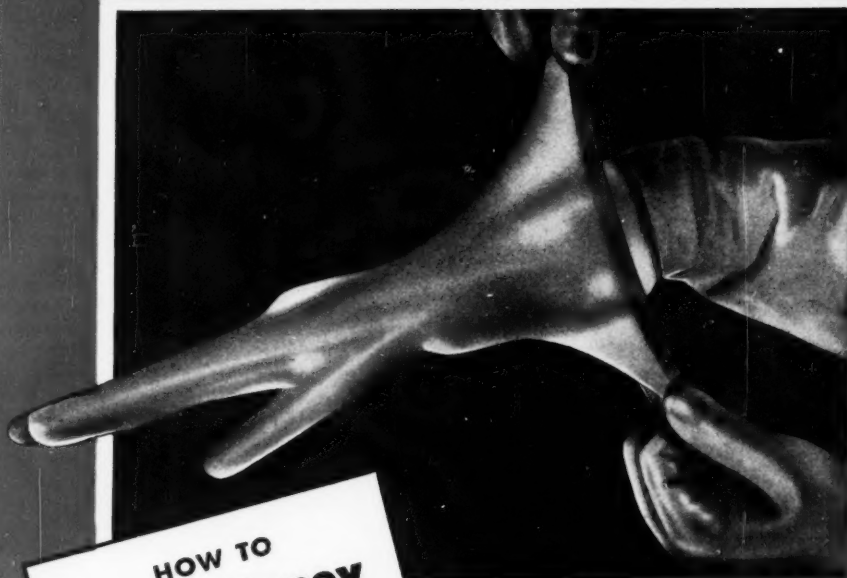
SURGICAL DRESSINGS DIVISION  
THE SEAMLESS RUBBER COMPANY  
NEW HAVEN 3, CONN., U. S. A.



relatives or friends on whom they can call in time of need. You will help them and us if you will donate a 'Good Samaritan Dividend' when you and your friends come to the Blood Bank to make a donation."

The new folder is part of the hospital's current campaign to bring in 600 blood donors a month. It is being distributed by the admitting, credit and

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## Reader Opinion

### Washers

Sirs:

The following paragraphs should be substituted for copy appearing under the heading, "Laundries and Laundry Equipment," on page 73 of the book, "Design and Construction of General Hospitals," prepared by this office and

published by The Modern Hospital Publishing Co.; and for copy appearing on page 96 of your magazine for April 1948, in the article on laundry equipment furnished by this office. The following is a correct description of the equipment discussed in both these source articles:

## Your Hospital— and Your Public



**T**HE SUREST MEANS OF LEARNING how your community regards your hospital is a campaign to raise funds for expansion or rehabilitation.

Your friends rally to your side quickly.

Your critics soon will be active, circulating complaints of conditions that you have never suspected. To be sure, the mere statement of some complaints provides its own answers. Often a criticism is based on ignorance or misunderstanding that a simple explanation will dispel. But, sometimes, the way is pointed toward necessary change of administrative procedure.

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"When selecting the number and size of washers, it is generally anticipated that the manually operated washers will readily produce from six to eight loads per day as compared to eight to 10 loads readily produced by washers having simplified unloading features and automatic or semiautomatic controls.

"One or more large washers should be provided for the main load, with a smaller one to take care of special work in small quantities and odd lots.

"Gutters are required in the floor to receive the water from washers. Drains should be of ample size, usually 6 inches, and should have removable screens to catch lint. Heat transfer reclaimers to extract and use heat from the wash and rinse waters will prove a real economy."

Marshall Shaffer  
Chief, Technical Services

Division of Hospital Facilities  
Public Health Service  
Federal Security Agency  
Washington, D.C.

### Building Costs

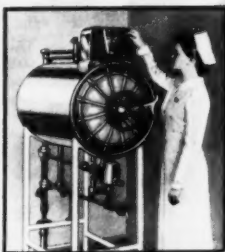
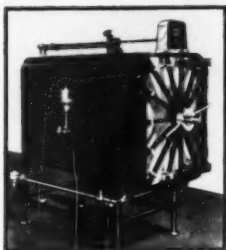
Sirs:

We have noted with interest your article in the July issue of *The Modern Hospital* entitled "Is This the Time to Build?" We feel that some comment is in order regarding the statement that a Texas architect claims to design hospital buildings of less than 100 beds in a one-story structure at a cost ranging from \$2820 to \$3870 per bed. You stated in your article that this was hardly credible, a statement in which the undersigned heartily concurs.

My reaction is that before costs of this kind are publicized, complete and satisfactory investigation should be made in order to determine whether the claim was that of a "super magician" or one who has merely provided bed

The MODERN HOSPITAL

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space in hospital buildings where the recommended minimum requirements for good hospital planning have been entirely disregarded. We are interested in knowing, and doubtless you have the information, if these buildings do comply with even the minimum requirements and if they are of fireproof construction.

Our latest small hospital effort reflects a building cost of better than \$15 per square foot, exclusive of furniture and equipment. This contract was awarded about a year ago, and should show now a saving of from 5 to 10 per cent. While the hospital was planned administratively and surgically as a 100 bed unit, only 42 beds are now provided. This, of course, raises the cost per bed above that which it would have been if the 100 beds were provided in the building now. The cost reflected in this building was approximately \$8000 per bed without furniture and equipment, but including, however, sterilizing, x-ray and certain kitchen equipment. We thought we had an economical building.

We are writing this because we think this article, quoting such low costs, may cause some bitter disappointments among those planning to erect modern, efficient hospital buildings, wherein the buildings contain standards of good planning. It is rather hard for the other 99 per cent of us to prove that our buildings are worthwhile in the face of these quoted costs. After all, within certain restricted limits, you only get what you pay for in both space and quality in any building.

Dahl Dewees

Phelps & Dewees & Simmons  
Architects  
San Antonio, Tex.

Sirs:

In your July 1949 issue under the heading "Is This the Time to Build?" a Texas architect was quoted as designing hospitals for a construction cost of \$2820 to \$3870 per bed. We believe that both you and William O'Connell of the Texas State Department of Health, to whom a copy of this letter is being forwarded, will be interested in our recent experiences relative to hospital costs exclusive of equipment, which are as follows:

Calhoun County Memorial Hospital, Port Lavaca, Tex. This building, now under construction, consists of a one-story, 20 bed general hospital having an "F" shaped plan with a square footage of 10,259 and cubic footage of 131,623.

The building is of fire resistant construction with concrete foundations and floor slab, exterior walls, face brick and hollow tile with stone trim, roofing of wood deck on steel bar joist with a wall bearing exterior, and steel interior columns and beams, metal windows, wood doors. Air conditioning in the operating section only. The low bid was \$201,853, which results in a per bed cost of \$10,092.

Panola County Hospital, Carthage, Tex. This is a 50 bed general hospital, now under construction, with a square footage of 26,719, of reinforced concrete construction, two stories high, exterior walls of face brick and hollow tile, interior partitions of solid plaster, steel casement windows, wood doors, air conditioning in operating and delivery rooms. The low bid was \$441,130.69, resulting in a per bed cost of \$8,822.61.

Baptist Hospital of Southeast Texas, Beaumont, Tex. This is a four-story, 136 bed general hospital, now practically completed. "T" shaped plan of reinforced concrete construction with exterior walls of face brick and stone trim, interior partitions of tile and plaster, floor of asphalt tile generally, plaster ceilings. Floor area of 59,352 square feet, a construction cost of \$1,088,108.20 with a per bed cost of \$8,000.80.

I hope that the foregoing might serve some purpose.

D. H. Oertel

Wyatt C. Hedrick  
Architect and Engineer  
Houston, Tex.

## Foreign Abstracts Sirs:

I have been wondering whether The MODERN HOSPITAL would be interested in starting a section giving summaries of articles from foreign journals on hospitals.

It would seem to me that we pay entirely too little attention to some of the foreign publications which have some very good material in them. I should think that it would be interesting to have a half page or even a page similar to the type of thing the *Journal of the American Medical Association* has on articles in foreign publications. I have thought it might be a project which some of my administrative residents could undertake.

Richard T. Viguers  
Administrator

New England Center Hospital  
Boston



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### TO HELP YOU PLAN EFFICIENT CABINET, COUNTER AND SINK INSTALLATIONS



*If you expect to build or remodel, you can obtain effective help from Blickman's expert layout and engineering service. Our experience in practical planning and installation is at your service . . . What size cabinets or counters will you need? . . . How should they be arranged? . . . What layout is best? . . . We'll answer these and other questions and be glad to draw up complete plans for step-saving, time-saving layouts. Of course, there is no obligation. Simply send us your building plans, or call us in. If your plans are completed, we will furnish a prompt quotation. For many years, Blickman-Built cabinets, counters and sinks have been giving excellent service in operating rooms; central supply and work rooms; milk formula, sub-sterilizing, utility rooms and other locations where hard use required the finest construction. Our units are available in stainless steel or enameled steel.*



SEND FOR HELPFUL BULLETIN NO. 10CBC. Illustrates and describes metal cabinets and case work for every department of the hospital. Blickman-Built cabinets and case work are available in all or part stainless steel. Construction types include recessed, wall to wall, free-standing, wall-mounted and counters with or without sinks.

#### NURSES' WORK ROOM Jersey City Medical Center

▲ A complete stainless steel installation. Important institutions choose Blickman-Built equipment because they meet the most exacting standards for durability, sanitation and efficiency.



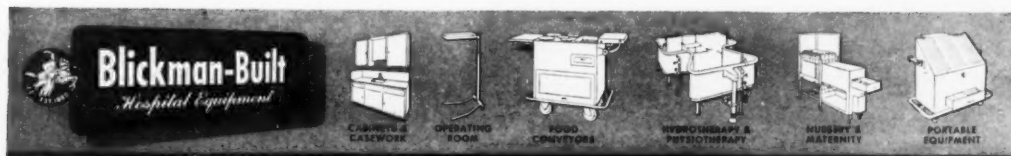
#### ▲ NURSES' STATION SINK and CABINET

#### ▼ BUILT-IN OPERATING ROOM CABINET

Stainless steel. Combines viewing box, solution warmer and instrument cabinet.



S. BLICKMAN, INC., 1512 GREGORY AVE., WEENAWKEN, N. J.



# ANNOUNCING THE KIRBY-THURSTON CHOLELITHOPHONE



- For locating gallstones at time of operation
- More sensitive than rubber gloved fingers...
- More reliable than grasping forceps...



ANOTHER NEW  
INSTRUMENT BY—*Pilling*

THIS easy-to-operate electro-acoustic device will detect and locate difficult-to-find gallstones at the time of operation.

When inserted into the duct, the sensitive probe upon contacting a stone can relay a characteristic signal to a loudspeaker. The amplifier can be tuned in before operation and set, or reset during operation if necessary, according to the surgeon's individual needs.

Although designed originally for gallstone location, its use has been suggested for the detection of other calculi. *Still other uses now under investigation* hold promise of further practical application.

The Kirby-Thurston Cholelithophone satisfies a surgeon's requirements for a practical instrument to detect and locate duct stones, and an engineer's specifications for trouble-free electronic construction.

Maintenance is simple, demanding no special skill. Probe parts are sterilizable. Upkeep is inexpensive, requiring only tube and plug-in condenser replacements once a year—at time of checking. It operates from any 115V 60 cps A.C. outlet.

A comprehensive brochure is available. Write for your copy today. This instrument is sold *exclusively* by Pilling. Orders are accepted and filled directly by

*George P. Pilling and Son Company*

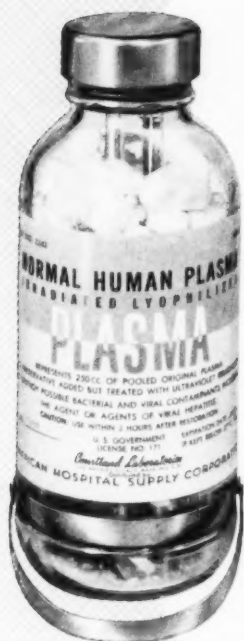
3451 WALNUT STREET  
Philadelphia 4

*A Standing Invitation: When in Philadelphia, visit our new salesrooms. Free parking on our private lot.*



PILLING FOR PERFECTION IN SURGICAL INSTRUMENTS

# Now—Normal Human Plasma Irradiated—Lyophilized with **BUILT-IN FILTER**



Your nurses spend no time in cleaning or preparing filter sets when you use the new COURTLAND NORMAL HUMAN PLASMA. You can administer it with *complete safety*, for no preservative is added and it is treated with ultraviolet irradiation to destroy possible bacterial and viral contaminants including the agent of Infectious Hepatitis. Then, you have the additional advantage of a built-in 200 mesh stainless steel filter. No filter is necessary in *your* intravenous equipment.



**Cut-away Plasma Bottle Stopper** shows the fine mesh filter. After restoration to liquid state, plasma passes through hole in glass tube at "A" and then through filter.

## AVAILABLE IN THREE SIZES

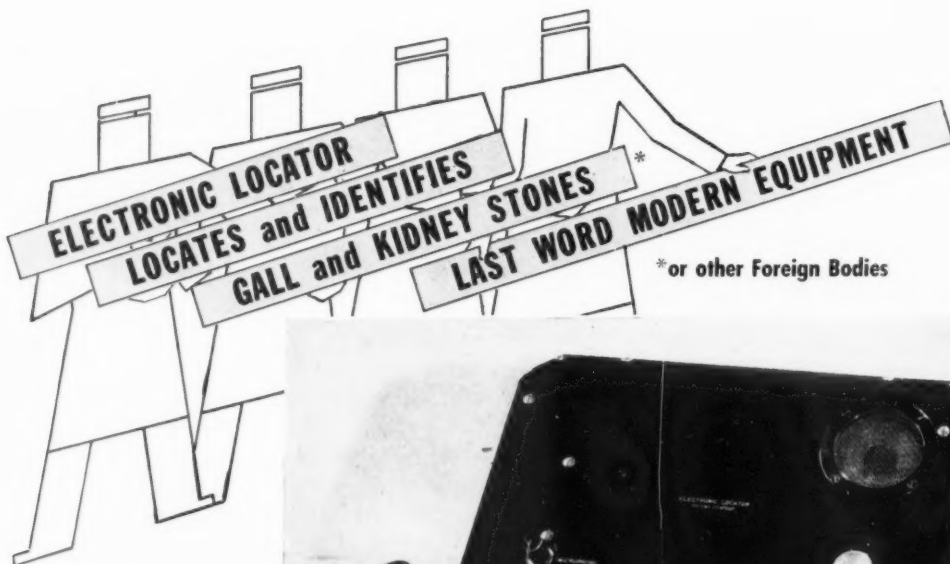
COURTLAND PLASMA is available in 50cc., 250cc. and 500cc. units. Prepared under National Institute of Health specifications, it is rapidly frozen at extremely low temperature, dehydrated under high vacuum (lyophilized) and sealed under vacuum in the dispensing container. A bottle of distilled water and a double-end needle for mixing water and dried plasma are included in every package.

You'll find it practical to keep COURTLAND PLASMA on hand for emergency use, for every unit has a shelf-life of five years. Plasma is immediately available from any AMERICAN office.

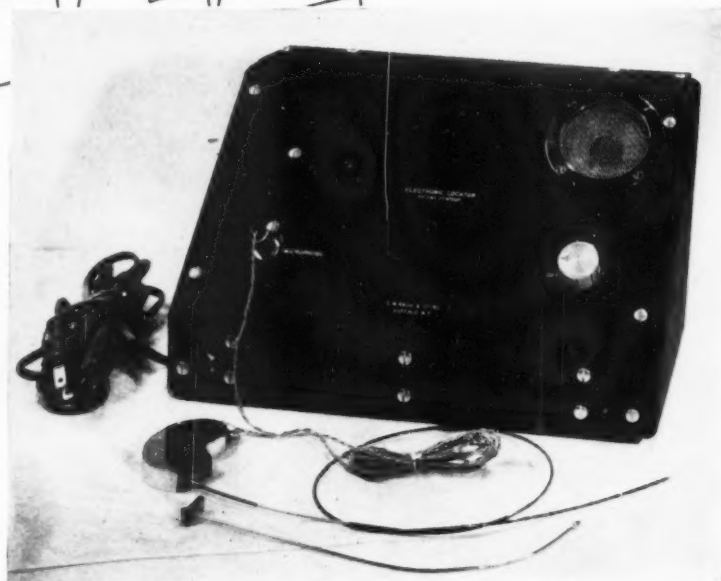


**PLAN WITH AMERICAN**  
... the first name in hospital supplies

**AMERICAN HOSPITAL SUPPLY CORPORATION**  
GENERAL OFFICES • EVANSTON, ILLINOIS



The Weckmen — symbolical of the items offered by the 60-year-old House of Weck, — offer you something new — the last word in modern equipment.



A foreign body—be it gall stones, kidney stones, or other foreign body—is identifiable by the sound produced. For example, a different sound is produced by contact with a stone than by contact with scar tissue.

On this principle there has been developed something revolutionary in the way of a locator—the RAUH ELECTRONIC LOCATOR, pictured above, only 12" wide.

The complete unit comprises a sensitive electromagnetic transducer, a high gain amplifier, and a loud speaker which is located on the amplifier panel.

The transducer converts minute mechanical displacements into electrical impulses which are fed to the amplifier through a small diameter (less than  $\frac{1}{16}$  inch) flexible cord. These impulses are amplified and made audible as sounds which characterize the material causing the original deflection of the transducer armature.

Probes of various types are obtainable which permit investigation of the common duct and other areas for gall stones at time of operation. A ureteral probe is available for locating stones or obstructions in the ureter. A probe in the form of a fine thumb forceps has been developed for locating and removing foreign bodies such as glass or pieces of metal or wood splinters which are imbedded in the tissues. These various probes are instantly interchangeable with-

out resort to chucks, thumbscrews, or other devices requiring mechanical adjustments.

The Transducer and Probes (without the cord) may be autoclaved, boiled or cold sterilized. The transducer and probes are completely isolated from any current.

The ELECTRONIC LOCATOR has a definite place in the modern-equipped hospital. It will be found a valuable adjunct to equipment in the Operating Room, Urology Department and in the Emergency Surgery. It will also serve as a check before closure at end of the operation. Maintenance is simplicity itself, upkeep almost nothing.

ELECTRONIC LOCATOR, for operation on 110 volt., 60 cycle current, complete with 1 probe and subject usual WECK GUARANTEE—unconditionally—\$295.00. Extra probes quoted on request.

**WECK also offers the new Rauh Surface Pyrometer**

Higher sensitivity—Skin Temperature readings in 1 second—direct reading—portable—attractively housed in 8" square mahogany case, calibrated for reading either Centigrade or Fahrenheit, range of 60° F. to 110° F. Operates on two small dry cell batteries. \$173.00

Accepted Council on Physical Medicine American Medical Association.

REMEMBER WECK INSTRUMENTS ARE MADE CORRECT—SOLD DIRECT—to HOSPITALS!

**EDWARD WECK & CO., INC.**

Manufacturers of Surgical Instruments

SURGICAL INSTRUMENT REPAIRING • HOSPITAL SUPPLIES

135 Johnson Street • Brooklyn 1, N.Y.





To Give Your Surgeons New Hand Comfort

*Specify* **ROLLPRUF**

**PIONEER SURGICAL GLOVES**

Surgeons have told us time and again that Rollprufs have excellent qualities not found in other surgical gloves. Here are some of the reasons they like Rollprufs:

*Flat banded cuffs* — this exclusive Pioneer development stops wrists from rolling down during surgery — reduces tearing.

*Durable* — Rollprufs are processed to stand extra sterilizings, give you longer glove life for your money — yet they're sheer, offer added sensitivity to surgeon's fingers.

*Comfort-fit* — all Rollprufs, both latex and neoprene, are more comfortable, less tiring over periods of long wear.

*Pioneer Rollprufs* — are made of finest natural latex and of DuPont neoprene. Neoprene Rollprufs are made in the new hospital green color for easy sorting. Experience shows they are free of the dermatitis-inducing allergen sometimes found in natural rubber.

Adopted by many hospitals all over the country, Rollprufs are more for your money. Specify Rollprufs — insist on them from your supplier or write us. *The Pioneer Rubber Company, 750 Tiffin Road, Willard, Ohio.*



Pioneer Skin Finish Rollprufs — made of latex rubber, new skin soft texture. Non-slip finish on fingers adds remarkable new sureness to surgeon's touch. Flat-banded cuffs — no roll down.



Pioneer Autopsy Gloves — durable, comfortable, lightweight neoprene gloves. Non-slip finish for greater dexterity.

See our complete Surgical Glove Catalog in Hospital Purchasing File.

**PIONEER**

*Surgical Gloves*

★ The Result of Over 30 Years of Quality Glove Making ★



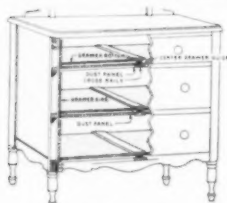
# WOOD

*... unsurpassed  
for Basic Harmony*



**CARROM FURNITURE CRAFTSMEN**

*Build* **FOR THE DECADES**



**DUST PANEL  
UNDER EACH DRAWER**

Carrom furniture is given every good construction feature that cleanliness as well as hard service requires. As an example, cracks, crannies and crevices are eliminated by close, secure fitting of joints and a panel under each drawer not only helps further to keep out dust and dirt but reinforces the entire construction — adding rigidity.

As the violin is unchanging in its contribution to good melody, so too must institutional furniture be so basic in its relationship to successful decorative schemes that years can never affect the artistic certainty that it "belongs."

Carrom Wood Furniture is especially made to meet institutional needs for furniture unchanging in style . . . simple and clean-cut in design. It is created to provide harmony so basic . . . in feeling, balance, appearance and good taste . . . that even decades cannot outmode. Its combination of gentle curves, straight lines and functional adaptability eliminate for the institution risks that must accompany furniture of novel appearance, doubtful and passing styles.

Aside from its basic styling, Carrom Fine Wood Furniture offers enduring strength in smoothly and permanently fitted joints and over-all good construction that years of hard institutional service demand.

Choose the furniture built especially for your requirements and you will choose Carrom Fine Wood Furniture, made by craftsmen who "build for the decades."

**CARROM INDUSTRIES, INC., LUDINGTON, MICHIGAN**

New York Office: 19 W. 44th St., Ralph Berg • Chicago Office: 1503 N. Sedgwick Ave., James L. Angle

# CARROM



**WOOD FURNITURE  
FOR HOSPITAL SERVICE**

## Pittsburgh Color Dynamics

uses energy in color to  
speed convalescence  
... increase efficiency  
... inspire trust and  
confidence in your  
institution.



## A simple request brings you an attractive COLOR DYNAMICS Plan for your hospital... FREE!

**W**HY does the use of one particular color in a patient's room speed convalescence and recovery more than another?

How do graduated steps of receding tones in a labor room relieve the feeling of claustrophobia so often experienced by the patient.

**How can color** assist the surgeon in his important task—or keep nurses more alert at their posts?

Pittsburgh's science of COLOR DYNAMICS answers these questions. For years psychologists and medical authorities have known about color therapy. Many of them have worked with Pittsburgh's color experts and technicians to establish the degree of influence of colors upon human beings. Out of these

joint efforts have been evolved many of the practical details to utilize the energy in color.

**Many hospitals** have already made use of COLOR DYNAMICS. By such purposeful use of this color energy, greater relaxation, stimulation, comfort and cheerfulness have been provided for patients, doctors and nurses.

**We'll be glad** to make a complete and scientific COLOR DYNAMICS engineering survey of your institution for you on request—free and without obligation on your part.

We'll also send you a booklet containing the fascinating story of this new painting system and how it works.

### There's a Pittsburgh Paint For Every Painting Need

**WALLHIDE**—PBX, extra-durable; SEMI-GLOSS, for higher sheen; FLAT, for velvet-like finish; GLOSS, for severe service and frequent cleaning.

**LAVAX PBX ENAMEL**—durable finish for interior use. Dries quickly to an eggshell finish that eliminates glare. For wood, metal or other surfaces.

**FLORHIDE**—for floor surfaces; can be scrubbed repeatedly with soap solutions.

Pittsburgh Plate Glass Co., Paint Div.,  
Department MH-129, Pittsburgh 22, Pa.

☐ Please send me a FREE copy of your new revised and enlarged Booklet, "Color Dynamics."

☐ Please have your representative call for a Color Dynamics Survey of our properties without obligation on our part.

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Street \_\_\_\_\_

City \_\_\_\_\_

County \_\_\_\_\_

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FREE BOOKLET! ➡



**PITTSBURGH PAINTS**  
PAINTS • GLASS • CHEMICALS • BRUSHES • PLASTICS

PITTSBURGH PLATE GLASS COMPANY



HOW TO PRESCRIBE A

# Reducing Diet

FOR HOSPITAL

# Flooring Costs:

Rx

Specify Tile-TeX  
Asphalt Tile  
Day after Day...  
Year after Year.

You cut flooring costs *two ways* with Tile-TeX®.

Because material cost is low, and because installation is quick and simple... *your first cost is low.*

Now combine this low first cost with Tile-TeX's extraordinary durability. (Many Tile-TeX floors have been in service for more than 20 years, without visible signs of wear.)

Then, keep your Tile-TeX floors at their brilliant best with this simple, inexpensive maintenance formula:

daily sweeping to remove loose dirt, periodic washing, water waxing (if desired).

And that's your *second saving*... in *low cost per year.*

In addition, you get Tile-TeX's unusual versatility. Tile-at-a-time installation gives you almost unlimited pattern possibilities. And, custom-cut inserts allow you to set designs right *into* the floor. Use them to identify wards and divisions, or merely for decoration.

And the wide range of rich colors means you can pick a floor to harmonize or contrast with any motif... gay and stimulating, or quiet and restful.

Get complete details on the many applications Tile-TeX offers for hospital floors. You'll find you can prescribe a *pleasant* reducing diet for flooring costs. Write today for special literature. THE TILE-TEX DIVISION. The Flintkote Company, Dept. H., 1232 McKinley St., Chicago Heights, Illinois.



**TILE-TEX...The Quality Asphalt Tile**

\*REGISTERED TRADEMARK, THE FLINTKOTE COMPANY

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*Martex*

*Fairfax*

towels • toweling • bathmats  
**AND NOW**

**NEW** sheets and pillowcases  
type 128—type 140

*Ability to withstand brutal wear and to give long, satisfactory life in hard service is true of both MARTEX and FAIRFAX cotton towels and toweling. These sturdy quality towels are woven especially to assure economy in use.*

*The same ability to withstand hard wear is also true of the new, lovely but durable FAIRFAX sheets and pillow cases.*

## "I love the towels here— they're MARTEX."

Your women patients can—and do—appreciate the loveliness of MARTEX name-woven terry towels. Hospital management also appreciates MARTEX terry towels, but for a very practical reason—they wear longer.

MARTEX terry towels are built to last. Their plied yarn ground warp construction insures longer life and greater resistance to unusually severe hospital usage.

Check on your records of length of towel life in use and you'll always specify MARTEX on your towel purchase orders.



products of **WEST POINT MANUFACTURING COMPANY**

**WELLINGTON SEARS COMPANY**, selling agents

65 Worth Street, New York 13, New York

BOSTON CHICAGO DETROIT ATLANTA PHILADELPHIA SAN FRANCISCO LOS ANGELES NEW ORLEANS ST. LOUIS

# Nobody throws away Stainless Steel



Stainless steel *lasts*. Allegheny Metal stays bright and strong—gives lifetime service—under conditions of corrosion, heat and wear that send lesser metals to the junk-pile in a few years, or perhaps only months. Wherever a superior metal will give you advantage, you'll find it cheapest in the long run to use Allegheny Metal, the time-tested stainless steel.

*Complete technical and fabricating data—engineering help, too—yours for the asking.*

## ALLEGHENY LUDLUM STEEL CORPORATION



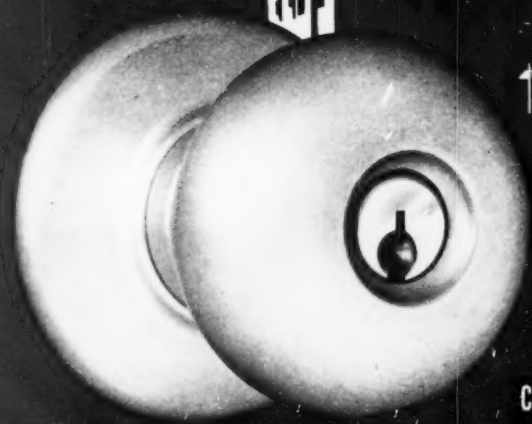
*The Nation's Leading Producer of Stainless Steel in All Forms*

Pittsburgh, Penna. . . . Offices in Principal Cities

Allegheny Metal is stocked by all Jos. T. Ryerson & Son, Inc., Warehouses

# SCHLAGE

...first name in cylindrical locks



## Chicago's Wesley Memorial Hospital

a Schlage installation of heavy-duty cylindrical locks.

Architects: Fegard, Burt and Wilkison  
Engineers: Thornton & Fegard

Cambridge Design

Illustrated at left was used in this outstanding  
hospital.

# SCHLAGE

## LOCK COMPANY

SAN FRANCISCO • NEW YORK

# "TROUBLE - ECTOMY"

**durable, easily cleaned walls**



SCHOOLS



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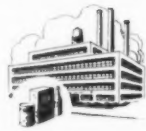
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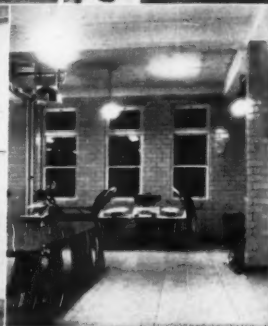
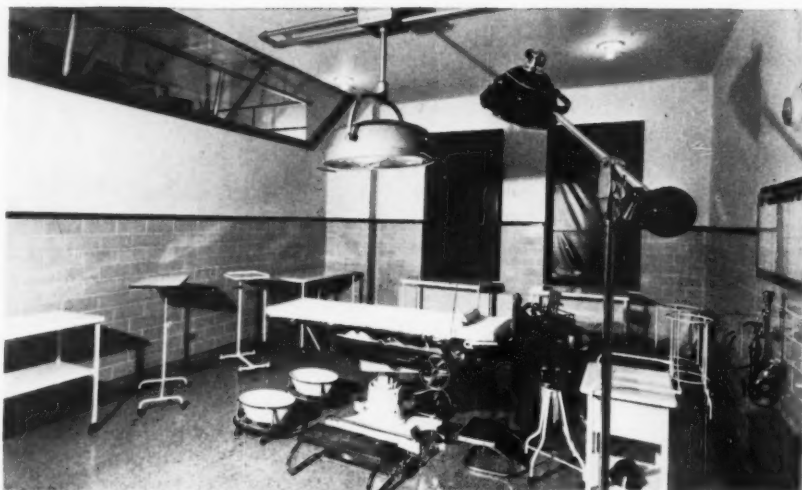
TRANSPORTATION



RENTAL HOUSING



PUBLIC BUILDINGS



Glazed Facing Tile

**for hospital interiors**

**of** *Facing tile*

**H**ere's a completely painless administrative operation that *cuts out trouble*—quickly, cleanly, finally.

You simply select Structural Clay Facing Tile for your hospital interiors.

When you do, you get walls that can be kept clean, *really clean*, with no more attention than a quick soap and water washdown. The surface is tough and *impervious* to every unsanitary trouble-maker.

Facing Tile interiors will never need refinishing or costly repairs because they will not crack, scratch or decay, even after years of hard wear.

In addition you get walls that radiate a cheerful "get-well" atmosphere throughout the hospital. You can choose pleasant, light-reflecting colors appropriate to every hospital function in the wide range Facing Tile makes available.

Structurally, Facing Tile gives you the advantages of a strong, durable, firesafe *wall and finish* in one material, at one cost! It is made both glazed and unglazed in efficient modular sizes.

**SEND FOR FREE FACING TILE CATALOG!** Get complete detailed information about the use of Facing Tile in your hospital. Yours on request. Just write the Institute, Desk MH-12, on your letterhead.

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Continental Clay Products Co.  
Kittanning, Pennsylvania  
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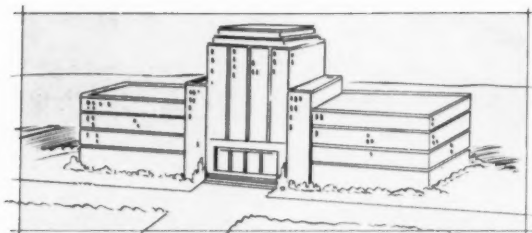
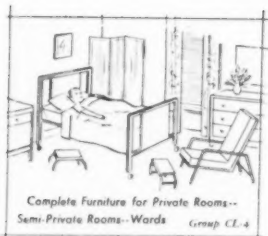
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**LIFE** IN THE MODERN HOSPITAL MOVES IN EASE AND COMFORT

AROUND



PRODUCTS BY HARD!



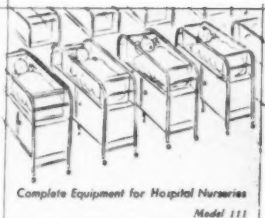
From reception room up to surgery  
Hard Mfg. Co. hospital furniture adds  
comfort, convenience . . . and long  
service to life in a hospital.



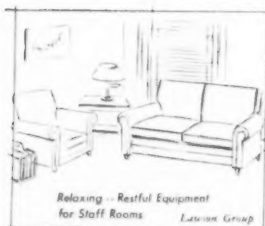
Made by specialists . . . sold through  
specialists who know and plan for  
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Whether it's beds or bassinets . . .  
cabinets or cots . . . ring cushions or  
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. . . you'll find HARD means Sturdy  
. . . Built-to-last . . . Built to serve.



Write for the name of your local se-  
lected Hard dealer and for our new  
catalog, "Modern Hospital Furniture  
and Bedding" to Dept. MH-12.



**HARD** MANUFACTURING CO.

BUFFALO 7, NEW YORK

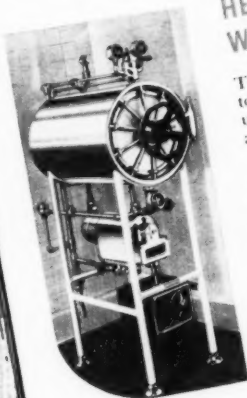
# American Sterilizer Company standardizes on Monel

## - for sterilizers that Bring You Long Life

### ...Good Looks...Corrosion Resistance



#### HERE'S EQUIPMENT DESIGNED WITH YOUR NEEDS IN MIND!

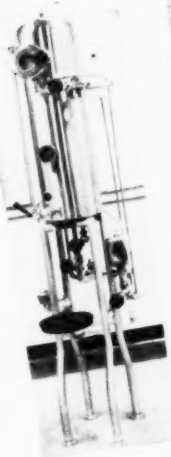


These sterilizers are built to last. They're built to keep their good looks. They're built to stand up against heat, steam, moisture, acids, alkalis and a wide range of hospital solutions.

That's why AMERICAN STERILIZER COMPANY, Erie, Pa., standardizes on rustproof Monel\* for chamber and steam jacket shells, for trays and supports of the pressure-type surgical supply unit at the left. And why they use only Monel for all their non-pressure as well as other pressure-type sterilizers like the water sterilizer on the right.

Monel is tough and strong. It's hard and smooth. It is solid, corrosion-resisting metal all the way through. There's nothing to chip off or wear away. Severe service and constant cleaning never dim Monel's original silvery lustre.

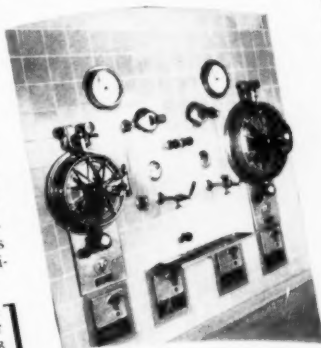
Put in Monel equipment. Remember—Monel looks good—and stays good—year after year.



#### PLUS VALUES FOR RECESSED INSTALLATIONS, TOO!

Preferred by many hospitals, built-in sterilizers can also be obtained in Monel construction from AMERICAN STERILIZER COMPANY.

Pictured here are two pressure water sterilizers (center) with Monel reservoirs. The recessed pressure-type instrument sterilizer and surgical supply sterilizer which flank them have Monel chamber and steam jacket shells, as well as trays and supports of the same durable metal. Equipment like this serves dependably, and is extremely economical to maintain.



[For detailed information about these and other Monel-equipped sterilizer models, write AMERICAN STERILIZER COMPANY, Erie, Pa.]

...A Good Bet  
for Sterilizers



EMBLEM OF SERVICE



THE INTERNATIONAL NICKEL COMPANY, INC.  
67 Wall Street, New York 5, N. Y.

\*Reg. U. S. Pat. Off.



Structural Control  
of **Curity**  
REG. U.S. PAT. OFF.  
Catgut to Assure  
**Absorption That  
Progresses Right  
on "Schedule"**

As surgery is speeding to its conclusion, you can have the assurance that with the use of CURITY Catgut—every stage will be under control.

The effective performance of CURITY Catgut has been even further enhanced by TOTAL CHROMICIZATION plus *natural* ply adhesion.

This process represents a notable advance in achieving increased absorption control.

These, and other advantages of CURITY Catgut are a result of *Balanced Quality*—the "built-in" quality and control that means an extra margin of safety and a smooth, uneventful recovery.

**Curity** REG. U.S. PAT. OFF. **Balanced Quality assures proper suture function**

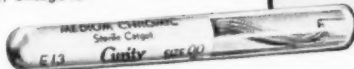
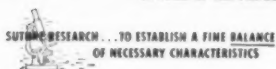
- adequate tensile strength
- ideal pliability
- gauge uniformity
- dependable absorption through uniform and total chromicization
- ideal strand surfacing
- absolute sterility
- minimal irritation

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Curity Suture Laboratories

**(BAUER & BLACK)**

Division of The Kendall Company, Chicago 16



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**T**ABLES of high individual merit, designed to meet every requirement of surgeon, of specialist and of general practitioner are included in the Ohio-Scanlan line. Noteworthy members are the new hydraulic Ohio-Scanlan A-6000 Major Operating Table with "Selectrol" positioner at the right side, head end, for selection and control of all postures—a table of unequalled convenience, efficiency and dependability; the Sisk Urological X-ray table . . . the Hawley-Scanlan Fracture X-ray and Orthopedic table . . . the Buie Proctoscopic and Examining table . . . the Braasch-Bumpus Urological X-ray table . . . the Nesbit combination table for eye, ear, nose and throat work . . . the Ohio-Scanlan delivery and obstetrical table . . . and an efficient, medium-priced, all-purpose operating table Model A 2003 B suitable for routine surgery and general service. Write for catalog, "Ohio-Scanlan General Operating Tables and Specialists' Tables." For immediate detailed information, call our nearest branch sales office.

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Heidbrink Anesthesia Apparatus  
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Oxygen • Nitrous Oxid • Cyclopropane • Carbon Dioxid  
Ethylene • Helium and mixtures • Also Laboratory Gases and Ethyl Chloride. Please return empty cylinders promptly.



**...pays for itself  
out of the  
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The speed and accuracy of National Mechanized Accounting result in savings that are always substantial...sometimes enough to pay for the entire installation in a relatively short time. Then, year after year, these savings continue in reduced accounting expense.

The National Window-Posting Machine operates on both the all-inclusive rate and the specific-service rate. *In one operation*, it posts the patient's bill, the account card, the journal sheet, and the posting voucher with machine-printed figures.

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**THE NATIONAL CASH REGISTER COMPANY, DAYTON 9, OHIO**

**National**  
ACCOUNTING MACHINES  
CASH REGISTERS • ADDING MACHINES

This "bomb"



**banishes**

**"hospital  
smell"**

**...to help  
you give  
better service**

What do family and friends of patients... and patients themselves remember about your hospital? One poignant memory will be the "hospital smell"... the unpleasant odor of anesthetics, disinfectants and wilted flowers.

Silver Label, the amazing new spray deodorizer banishes such odors instantly and at trifling cost. It's easy.

Just press the button and the odor is actually gone... not just masked by another odor! It's chemically killed by "Metazene"\* the wonderful, new deodorizing ingredient *exclusive* to Silver Label.

Make your hospital a more pleasant place for everyone by trying Silver Label now. An increasing number of hospitals are *already* using Silver Label. Ask your supplier. If he hasn't received his stock, mail the coupon below with \$1.69 (or \$5.00 for 3 bombs) today. We pay the postage.

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\*Metazene Spray Deodorant

A product of Boyle-Midway Inc.... the Makers of Old English Wax

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Enclosed is check for \$1.69 ☐ \$5.00

Please send postage paid One ☐ Three  
bomb(s) of SILVER LABEL Spray Deodorizer.

Name

Hospital

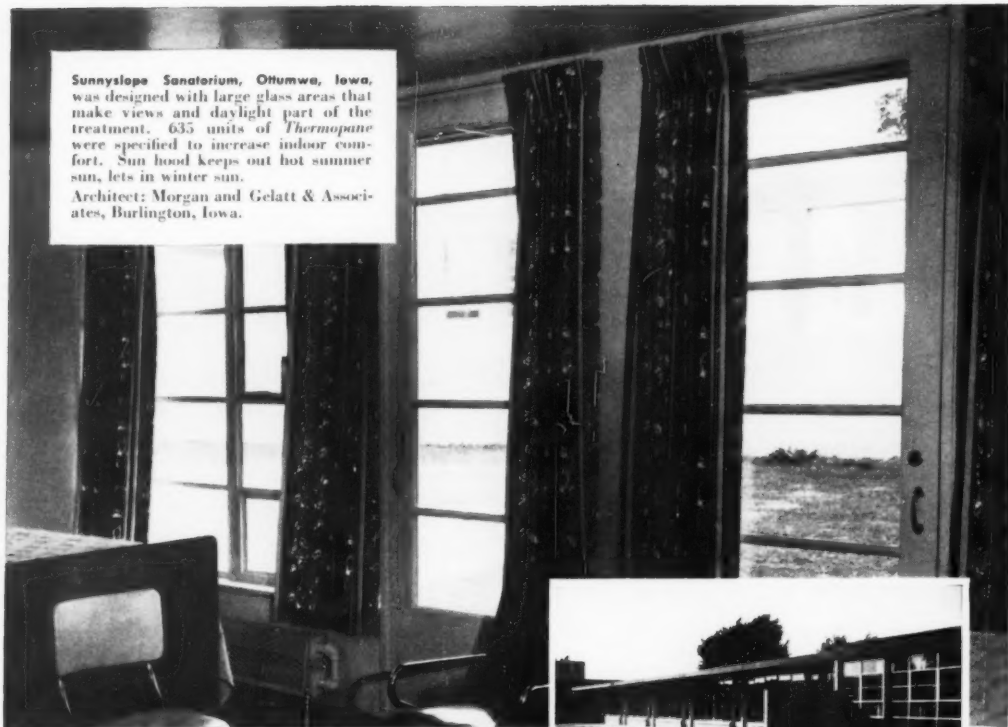
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Supplier's Name

Sunnyslope Sanatorium, Ottumwa, Iowa, was designed with large glass areas that make views and daylight part of the treatment. 635 units of Thermopane were specified to increase indoor comfort. Sun hood keeps out hot summer sun, lets in winter sun.

Architect: Morgan and Gelatt & Associates, Burlington, Iowa.



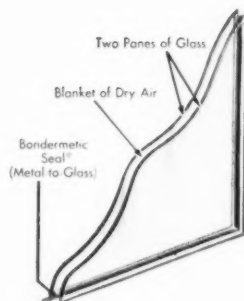
*Brighter outlook for patients*

## ... maintenance economy for Management

You can give patients the morale-building benefits of outdoor views and daylight... and still assure heating economy... by installing large windows of Thermopane\* insulating glass. This sealed, double-pane window lessens the load on heating and air-conditioning systems... makes it easier to regulate temperatures and humidities all year.

In winter, Thermopane greatly reduces fuel consumption, because the blanket of dry air between the panes cuts heat loss effectively. The inner pane stays near room temperature. This minimizes condensation on glass, even where high humidities are needed. Thermopane reduces drafts, too, assuring comfort for patients in beds beside windows. In summer, the sealed-in air space helps insulate rooms against outdoor heat.

For economy of construction and flexibility of design, Thermopane is made in over 80 standard sizes. Write for your free copy of our Thermopane book and Don Graf Technical Sheets.



Cutaway view of Thermopane

FOR BETTER VISION SPECIFY THERMOPANE  
MADE WITH POLISHED PLATE GLASS



**Thermopane**

MADE ONLY BY LIBBEY-OWENS-FORD GLASS COMPANY

29129 Nicholas Building, Toledo 3, Ohio



“The Vote was  
Unanimous!”



“ At a recent meeting of the building committee, the subject under discussion was the new Memorial wing. Like all these meetings, every phase of the construction, and the supplies needed for it, were being covered from the cellar to the roof. Finally the talk turned to the all-important subject of flooring . . . flooring that would be durable, attractive, and easy to clean. Well, the discussion was very brief. When the architect recommended

Hood Rubber Tile, the vote was unanimous. And why not? We've had Hood Rubber Tile in our hospital for 21 years and it's as good as new!

★ ★ ★ ★ ★  
For 25 years, hospitals across the country have enjoyed the longer wear, ease of maintenance, comfort, quiet, and blending beauty of Hood Rubber Tile. Let this be your guide to better flooring. Write for free color catalog and see why Hood is the choice.



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**HOOD—FOR ASPHALT TILE**

# The Outstanding All-round DISINFECTANT VALUE!

Here's why O-syl  
gives QUALITY performance at QUANTITY price!



**Swift—Sure!** Attacks all vegetative pathogenic bacteria and fungi. Yet—never fades or discolors floors, walls, bedding, furniture.

**Pleasant Odor!** Unlike many familiar disinfectants, O-syl never leaves any traces of disagreeable odor.



**Non-caustic — Non-irritating!** Potent—yet it never burns as an antiseptic rinse, or as an application on obstetric patients.

**Potent — Effective!** Completely safe and sure for the disinfection of dishes and utensils used by patients with contagious diseases.

**Economical!** Diluted 100 times, O-syl makes a thrifty, potent disinfectant solution for general use—for as little as 2.2¢ per gallon.

**Highly Concentrated!** Even when greatly diluted, O-syl is extremely powerful in its anti-bacterial action.



**Non-corrosive!** O-syl guards expensive instruments from rust, safely and surely disinfects rubber goods.



**Non-specific!** Eliminates the necessity of keeping several germicides for various specific purposes.

**FOR SAFETY'S SAKE...** the significant new development in disinfectants



*In one of New York's greatest hospitals O-SYL was used on women patients 77,000 times, with not one single case of irritation!*

O-SYL IS LISTED AT \$2.70 PER GALLON IN GLASS CONTAINERS.

5% discount for shipment in individual 5-gal. drums, 10% discount for shipment in individual 10-gal. drums, 20% discount for shipment in individual 50-gal. drums. Freight prepaid on 10 or more gallons shipped at one time to one address. Terms 2% 10 days, 30 days net.



Professional sample upon request. Call your hospital supply dealer or write direct to: Lehn and Fink Products Corp., Hospital Dept., 445 Park Avenue, New York 22, N. Y.

## SIX REASONS WHY YOU SHOULD CHOOSE

# Adlake Aluminum Windows

### 1. NO MAINTENANCE COST!

Adlake Windows need no painting, no maintenance other than routine washing.

### 2. MINIMUM AIR INFILTRATION!

A unique combination of non-metallic weatherstripping and patented serrated guides assures maximum weathertightness.

### 3. FINGER-TIP CONTROL!

You can raise and lower an Adlake Window with one finger—millions of times—each operation as smooth and fast as the one before.

### 4. NO WARP, ROT, RATTLE,

stick or swell, ever, with weather-defying Adlake Windows!

### 5. EASY INSTALLATION!

You put Adlake Windows into *completed masonry openings*. It's so easy to do that a perfect job is assured if the simple instructions are carried out.

### 6. STURDY, LUSTROUS ALUMINUM

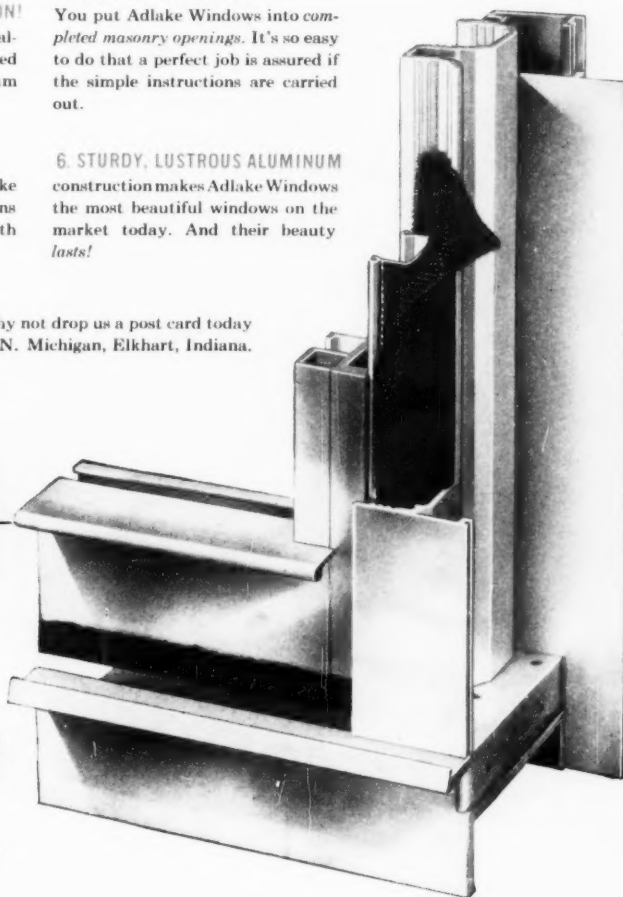
construction makes Adlake Windows the most beautiful windows on the market today. And their beauty *lasts!*

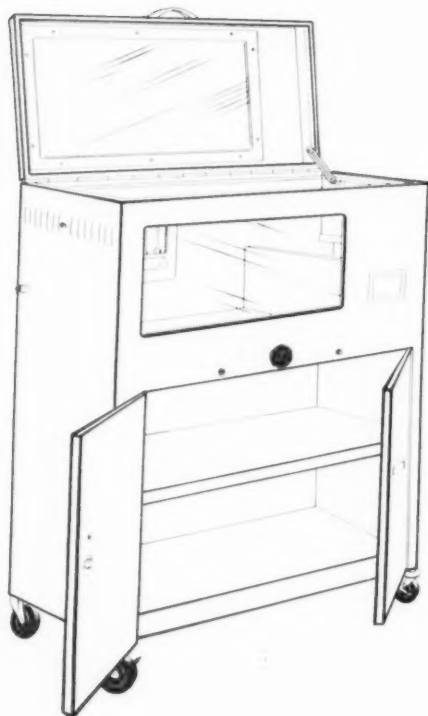
IF YOU PLAN to build or remodel, why not drop us a post card today for complete data? Address: 1105 N. Michigan, Elkhart, Indiana. No obligation, of course.



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Established 1857  
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With LIVSEY you have the kind of gentle, steady, even heating that is prerequisite in an infant incubator. Radiant heating units provide a constant temperature at all points within the incubator and eliminate any breathing difficulties which arise from hot air conditions.

You will also find LIVSEY'S convenient apparel warming shelf, directly under the infant compartment, indispensable for prewarming the infant's blankets and clothing.

Many other improved, modern features make the LIVSEY incubator more convenient, safe, and economical. Write today for a free brochure describing its many advantages. The LIVSEY Equipment Company, Dept. 11, 18938 Winslow Road, Cleveland 22, Ohio.

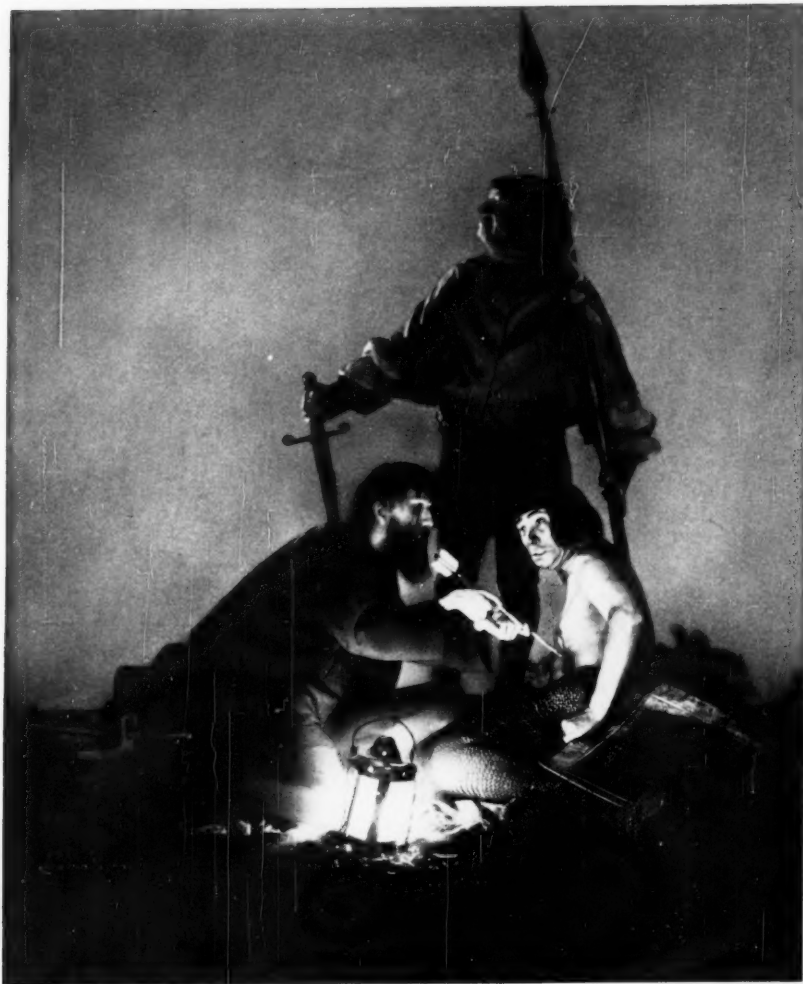


# LIVSEY

## INFANT INCUBATOR

The MODERN HOSPITAL

SUTURES IN ANCIENT SURGERY



*Jehan Yperman*

(1280-1351)

## INTRODUCING



... specially designed to meet requests for smaller needles for obstetrical, intestinal and abdominal closure.

... to replace with the Atraumatic principle such needles as regular surgeon's  $\frac{1}{2}$ -circle, Murphy intestinal, Mayo intestinal, Mayo catgut  $\frac{1}{2}$ -circle and others in comparable sizes.

... supplied with plain or chromic catgut in several sizes.

... developed in keeping with D & G's policy of providing a suture-needle combination for every surgical situation.

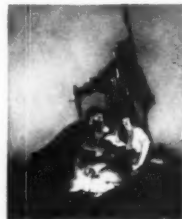
## D & G SUTURES

"This One Thing We Do"



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JEHAN YPERMAN (1280-1351) — Yperman was one of the most famous pupils of the great Lanfrank, distinguishing himself both as a surgeon and an author on surgical subjects. Among his writings are lucid accounts of his method of arresting bleeding from an artery by the use of a "triangular needle" and a "stout waxed thread." He also gave good accounts of his methods of trepanning, treatment of arrow wounds and the suturing of the skin following an operation for hare-lip. Yperman was appointed surgeon to the Ospial del Belle at Ypres in 1308.



# Which of These is Your Problem?\*

Expansion or Revision?

A New Hospital?

A Joint Appeal?

Public Relations  
& Goodwill?



Few hospitals, unless recently built or expanded, are able to satisfy public demand for their services.

Few communities are free from the problem of inadequate hospital facilities.

Both hospitals and communities are seeking a solution of the problem which, in many instances, is today tragically acute.

Both may find a key to the problem in the record and policies of the AMERICAN CITY BUREAU.

\* A booklet bearing this title, discussing the problems of hospital fund raising, was just recently mailed to you. If your copy has not reached you, we will be glad to send a duplicate upon request.

ALMOST 37 YEARS' CONTINUOUS EXPERIENCE; 2700 INDIVIDUAL CAMPAIGNS; PERMANENT AND TRAINED STAFF; HOSPITAL CAMPAIGNS NOW IN PROGRESS IN 10 COMMUNITIES.



"We wish to express  
our high praise for  
**Duraclay**\* It is the  
most sanitary and easy-  
to-care-for material in  
hospital fixtures."

Roy C. Green  
Vice President, GARDEN GROVE SANITARIUM  
GARDEN GROVE, CALIFORNIA

Pleasant grounds, ranch-type buildings  
distinguish the Garden Grove Sanita-  
rium. Patients are housed in a homey,  
25-bed building, treated in the hand-  
some medical building below.



Above, left, Duraclay Sits Bath in the Garden Grove Sanitarium. Like all Duraclay sinks and baths, it remains completely unaffected by sudden extreme changes in temperature.

- Duraclay is completely immune to thermal shock.
- Duraclay resists abrasion.
- Duraclay is stainproof.
- Duraclay cleans with the swish of a damp cloth.
- Duraclay doesn't craze despite years of constant usage.

Crane supplies Duraclay in a complete line of hospital sinks and baths. In making selections, check your requirements with your Crane Branch, Crane Wholesaler, or Local Plumbing Contractor. Write for free copy of Crane Hospital Catalog.



In addition to a full line of Duraclay items, Crane supplies the conventional fixtures for nurses' quarters, patients' rooms, etc., plus such specialized equipment as this hydrotherapeutic shower and control table, in use at the Garden Grove Sanitarium.

\* **Duraclay**

exceeds the rigid tests for earthenware (vitreous glazed) established in Simplified Practice Recommendations R-106-41 of The National Bureau of Standards.

# CRANE

NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

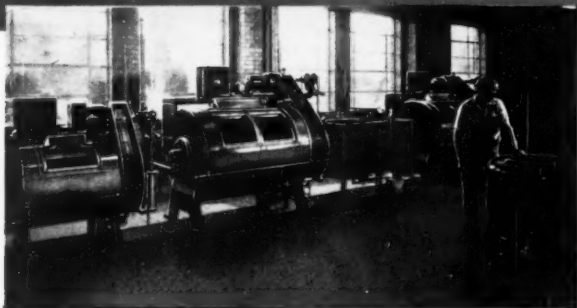
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PLUMBING AND HEATING •  
VALVES • FITTINGS • PIPE

The MODERN HOSPITAL

# American

## Modernized the Laundry Department



In bright new laundry building, three NOR-WOOD CASCADE Washers and 30" Extractor launder all linens and uniforms sterile-clean on short schedule.

at 150-bed  
St. Patrick's Hospital,  
Missoula, Montana

**Problem...** Operating costs of old, obsolete laundry were high. Equipment was unable to launder sufficient linens and meet quality standards of the hospital.

**Solution...** Our Laundry Advisor was called in. He analyzed hospital's laundering requirements, submitted recommendations and a suggested equipment layout. Hospital then installed modern, cost-reducing equipment in new laundry building.

**Results...** Generous supplies of fresh, sterile-clean linens and uniforms are always available for patients' rooms, surgical departments, laboratories, kitchens and dining rooms. Laundering quality is outstanding. More efficient operation and increased production have made new laundry a profitable investment.



Linens are beautifully ironed, quickly and economically, on this 6-Roll STREAMLINE Flatwork Ironer.

● Your hospital will benefit by selecting from our complete line of the most advanced and productive hospital laundry equipment.

● Hospitals, large or small, are invited to discuss their laundry problems with our Laundry Advisor. No obligation. WRITE TODAY!

*Remember...*

Every Department of the Hospital  
Depends on the Laundry

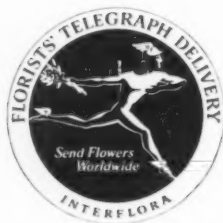


**THE AMERICAN LAUNDRY MACHINERY CO., CINCINNATI 12, OHIO**




**"That lady  
has friends...see  
those FLOWERS!"**

Yes, real friends rally round at convalescent time, sending  
FLOWERS-BY-WIRE. Both help patients feel  
better, faster, especially the FLOWERS.



And most F.T.D. members deliver Hospital  
FLOWERS in containers filled with chemically treated  
water that needs no replenishment.

FLORISTS' TELEGRAPH DELIVERY ASSOCIATION, 149 Michigan Avenue, Detroit 26, Michigan



## Porcelain on steel — a lifetime investment

This lustrous Armstrong tile is good for years of beauty and hard wear. Exclusive porcelain-on-steel construction makes it your best wall tile investment. Here's why:

● **Lasts the life of the building.** Armstrong's Veos Wall Tile will last a lifetime because it's made of genuine porcelain fused to a base of 20-gauge steel. Since porcelain and steel expand and contract at the same rate, this tile can never develop surface cracks or crazes.

● **Money-saving installation.** This lightweight material makes wall reinforcing unnecessary. Tiles are cemented onto a special foundation board which goes right over existing walls. This saves time and costly labor.

● **Rich, permanent colors.** Armstrong's Veos Wall Tile is made in ten attractive colors—permanent colors fused within the porcelain so they will always be bright and new looking.

● **Easy-to-clean surface.** This Armstrong tile is made like a fine sink or bathtub. Its smooth, glasslike surface wipes clean with a damp cloth.

Write for free descriptive booklet: Armstrong Cork Company, 5712 Frederick Street, Lancaster, Pennsylvania.



**ARMSTRONG'S VEOS WALL TILE**

## Small Hospital Questions

### Storing Frozen Foods

**Question:** At what storage temperature should frozen foods be maintained in order to reduce deterioration to a minimum?—L.F., Osla.

**ANSWER:** Most causes of spoilage can be stopped at 15° F. but chemical reactions proceed at lower temperatures. While a number of products can be stored satisfactorily at temperatures up to 15° above zero, it is a good general rule that holding storage should be zero. It must always be remembered that freezing does not destroy but only arrests the activities of microbes and enzymes. It does not completely protect products from vitamin loss. The loss of nutritive value, as proved by many tests, increases in proportion to the increase of temperature. Vitamin A in fruits and vegetables will drop significantly in six months' storage at 15° F. Even at zero as much as 25 per cent may be lost in peas held over from one season to the next. Vitamin C in spinach, for example, will remain unimpaired for eight months at zero but will be 25 per cent reduced in one month at 16° F. Beef can be held 15 months at zero but will show lowered quality in three months at 15° F.

Many other similar tests and examples have proved that zero storage is the temperature desirable for the safekeeping of frozen foods. It also must be emphasized that when storage temperatures are too high other desirable qualities are lost, such as the bright green color in peas.—COL. PAUL P. LOGAN.

### Saving by Softening

**Question:** Can you give us any idea of the amount of saving possible through using soft water for the laundry? We would also like to know at what point in the number of grains of hardness per gallon in water the use of water softeners becomes economical.—B.D.W., Mo.

**ANSWER:** Probably the best way to give the correct technical answer to this question is to quote from Bulletin No. 68, September 1949, of the National Association of Institutional Laundry Managers:

"Just as a matter of general information, a laundry processing 6000 pounds of linen per day in water of 10 grains hardness would have, in one year, a soap and builder wastage of approximately

\$5000 at prevailing prices. To this amount we can add an approximate figure of 30 per cent of the costs of all linens in service as a result of loss of life to all linens washed in hard water. The latter figure may easily treble the one for soap and builder wastage.

"Water with two grains per gallon hardness and the same volume of work would mean a soap and builder wastage in one year costing approximately \$800 plus the loss of approximately 10 per cent in the life of linens being processed, making a total loss per year of possibly \$1600 or more."

Therefore, if you weigh all the advantages, i.e. the elimination of the tangible disadvantages and the savings mentioned in the foregoing paragraph, water of two grains per gallon hardness should be mechanically softened before being used for laundering purpose.

Soap and builder savings alone normally effect sufficient savings to justify the installation of a mechanical water softener, but when we add the savings as a result of extended life to linens washed in softened water any and all doubt, if any exists, is obliterated.

Those who want to present facts regarding minimum anticipated annual savings of linens if soft water is used can easily prepare the necessary data by taking the totals of the inventory of linens in service and determine the number of replacements over a representative period, which will give the average life span of each item today.

After this figure has been obtained the following table can be used to approximate the savings resulting from softening the water:

10 per cent of the figure if water hardness is 2 g.p.g.

18 per cent of the figure if water hardness is 4 g.p.g.

25 per cent of the figure if water hardness is 6 g.p.g.

31 per cent of the figure if water hardness is 8 g.p.g.

35 per cent of the figure if water hardness is 10 g.p.g.

—E. W. JONES

### Special Nursing

**Question:** Should the hospital administrator, the director of nursing, or the patient's physician be responsible for denying special nursing to patients unless definitely indicated by their condition, or should this be a joint responsibility?—G.M.M., N.Y.

**ANSWER:** When private duty nursing service is organized and service is sought and assigned through the hospital as a registering agency, the nursing or administrative office may be responsible for explaining the situation to the patient and denying special duty care, if that becomes necessary; however, this should be done wherever possible with the knowledge and approval of the attending physician.

Where private duty nursing service is sought through an outside registry or agency, arrangements may properly be carried on through the attending physician. Again, however, there should be few cases in which the interests of the hospital, the nursing service and the physician are not identical, since the physician is the one who determines whether special nursing is "indicated by the patient's condition."

### What Is "Part Pay"?

**Question:** Is the "part pay" patient one who pays part of his bill or one whose hospital care is given at less than cost?—A.H.M., Wash.

**ANSWER:** As generally used, the term applies to ward patients whose care is paid for at billed rates which are less than the actual costs of the services rendered and charged for. The patient who pays part of his bill may be in either the part pay or full pay category.

Conducted by Jewell W. Thrasher,

R.N., Frazier-Ellis Hospital, Dothan,

Ala.; William B. Sweeney, Wind-

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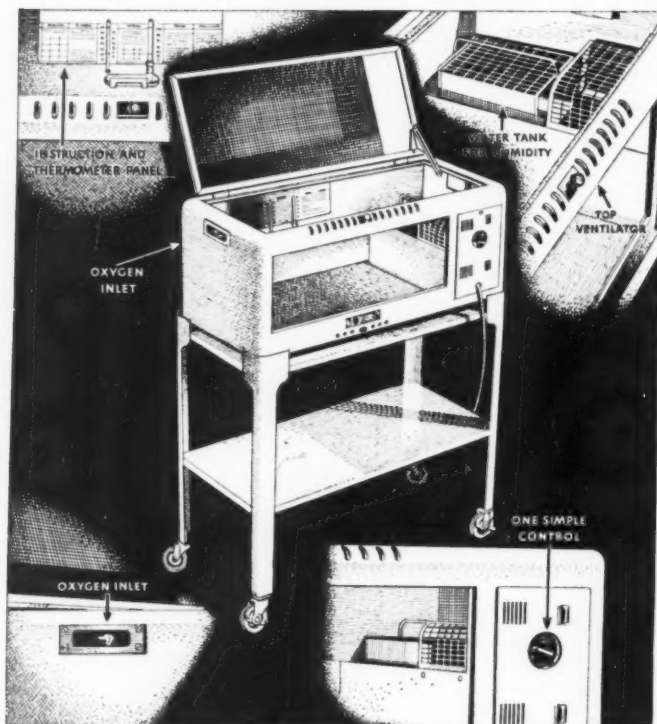
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# Looking Forward

## Mr. Smith Goes to Town

WRITING in the *Saturday Review of Literature* not long ago, Harrison Smith noted the fact that American writers uniformly "assert that we are unhappy and are driven toward a sense of futility and insecurity." Outside the advertising columns of our newspapers and magazines, we have no literature of hope. Instead, "Our writers have used their investigations as so many clubs to crush our somewhat naive hope that we are building toward a future that will be less menacing, more secure, and happier than today."

As Mr. Smith observes, this "aggressively negative literature produced by a country which would be inundated by tens of millions of people from every quarter of the globe if we opened the floodgates" is a fantastic spectacle. One might suppose the literature was designed to provide ammunition for our foreign enemies, it is suggested, "if we did not have the sense to know that it is a peculiarly American form of reportorial writing, with the intention of shocking the reader into accepting as normal the exaggerations of dangerous and ugly situations which might otherwise remain hidden from sight."

This shrewd observation may shed light on a phenomenon that has been bothering medical and hospital groups in recent years—the succession of books and magazine articles dramatizing the failures and weaknesses of our medical and hospital care systems. Sensational exposes about tyranny in our nursing schools and brutality in our mental hospitals have shared lurid headlines with scathing strictures on venality in the operating room and tuberculosis spreading needlessly in hospital wards. The view that such stories are all the result of a deep-laid, sinister plot to smear American doctors and hospitals breaks down quickly on inspection; the articles have been episodic in appearance and often contradictory in content.

Granting that the smear interpretation is absurdly chauvinistic, many thoughtful medical and hospital leaders have nevertheless maintained that publication of these critical articles was breaking down public confidence in hospitals and doctors and was thus definitely harmful. The Smith analysis should cheer them up, suggesting as it does that sensational literature in our time has become a game between author and reader. "Look, I am calling unnecessary surgery 'murder in the operating room.' *That* ought to wake you up!" chortles the author. "Another sensation, eh?" the reader murmurs in reply. "Say, I wonder if there's anything in this one?"

So long as both sides understand the rules of the game, and Mr. Smith has adduced some evidence to show that they do, it is likely that no great harm will result. That the exposé may, on the other hand, accomplish some useful purpose is apparent from the experience of a reporter who overheard two hospital people talking about the recent article on tuberculous infection in hospitals. For 10 minutes, they chewed the author of the article and the editors of the magazine unmercifully and brooded about the trouble that such bad publicity would cause.

"By the way," one of them remarked as they parted. "We're having a special meeting of our executive committee this week to discuss the possibility of starting a chest survey program."

## Good News From New York

WHATEVER one may think of their other choices, the voters of New York State acted wisely last month when they approved the \$150,000,000 bond issue for construction of additional hospital facilities for the New York City Department of hospitals. As professional people have long known, and as the public through-

out the state became aware during the campaign, city hospitals have been desperately overcrowded and hospital personnel shamefully overburdened. Newspaper pictures published in the campaign to inform the electorate about hospital conditions showed corridors solidly lined with beds or cots. The accompanying stories told of doctors, nurses and other workers whose staggering schedules and responsibilities failed to keep up with mounting demands for service; yet thousands in need were still unable to get hospital care.

Of course, the additional funds that are now forthcoming will not be available right away, and the new facilities will not spring into existence overnight. But needed relief is on the way, and knowledge that this is so will give the doctors, nurses, administrators and patients in city hospitals, as well as those who are waiting to get in, new hope which should help them carry their burdens in the meantime.

The New York vote is important throughout the nation. However comfortably the ward patient is provided for in Vermont, say, or in Indiana or Utah, the intolerable conditions which have prevailed in New York, and which still prevail in public hospitals in many other heavily populated industrial centers, are a threat to hospitals elsewhere. The patient who stayed on the bedpan for an hour because there wasn't any nurse to take it away, and whose bed was in a public corridor because there wasn't room for it anywhere else, will remember the humiliation and discomfort he has suffered long after he has forgotten the skill that made him well. His vote is the precise equivalent of the vote from a happier hospital environment, and ultimately it is votes that will determine the future course of our whole hospital system.

All hospital people can be thankful that conditions are going to be better in New York. A bed in a hospital corridor anywhere is a menace to hospitals everywhere.

## Matter of Fact

MOST administrators pridefully believe that their decisions and actions are based on facts. Executives in business, government, health and educational enterprises all concern themselves with facts of various kinds and sizes—or so they believe. Regard, or apparent regard, for facts is a major characteristic of our technological society. "It is a fact" is one of the most commonly used phrases in our language—and certainly one of the most abused.

What is a fact? Most people think they know the answer right away. A fact, they would say, is something that has actually happened—a definitive, discernible thing or circumstance. The philologist's definition supports this view. A fact is defined as "that which has actual existence . . . an occurrence, quality or relation the reality of which is manifest in experience or may be inferred with certainty."

A few minutes' reflection indicates that by all these concepts and definitions, a fact is much less exact than

we are accustomed to think. The actual happening must be observed and reported; the thing or circumstance must be discerned; the existence must be realized; the experience must be lived, the inference drawn. Inevitably, fallible human judgment becomes a part of what we call fact.

Who can say what a fact is? In medicine, some of the most significant developments of our time have come in the field of psychosomatic diagnosis, where cause and effect relationships have emerged as the result of shrewd assumption rather than observable fact. In medicine, too, mortality statistics are regarded as the most basic of facts, yet they arise from certificates signed by doctors who are sometimes guessing, often uncertain and rarely sure of the cause of death.

What is a fact? Reporters for two American papers visited England recently to study the National Health Service there. One reporter worked for a left-wing paper, the other for a staunch Republican. As it happened, they both visited the same doctor's office in London on the same afternoon, interviewing some of the 20 or 30 people in the waiting room, talking to the doctor and his assistant. "It is a fact," the Republican reporter wrote for his paper that night, "that under socialized medicine here the doctor is so overwhelmed with demands for service that he can't give anything like adequate care to patients who are really sick." A few doors away, the other reporter tapped out his story. "It is a fact," he wrote, "that under the government health service here many people are getting medical care who could never afford it before."

Both reporters might have been right, but neither one was reporting facts. The only fact of the matter was that there were so many people in the doctor's waiting room at a certain time—a meaningless circumstance, as true facts are likely to be until they are illuminated by human understanding. Knowledge of facts in the physical sciences has marvelously altered our environment, but outside the physical sciences, in the administration of human affairs, there are few if any real facts—however much we may delude ourselves to the contrary. It is time we recognized this and stopped talking so much about facts that aren't facts.

## P & P

BILLY ROSE, the poor man's pundit, wrote a newspaper column the other day about medical economics. "Too much for buildings and too little for brains" was his neat summary of where medical philanthropy has landed us. "In medicine as in many other things we have fallen into the same old trap—bigness," he concluded. "We have forgotten that bronze doors never developed a vaccine. Fleming discovered penicillin without the aid of Muzak in the men's room."

There must be a moral here for hospital trustees who spend a million or two on a building and expect the administrator to work for peanuts and posterity.

Critics of the federal government often forget the fact that expansion of federal operations almost always reflects a failure of voluntary effort to provide for essential needs, Eli Ginzberg points out in this challenging article on federal hospitalization. "Those who are truly concerned about the growth of government must act to strengthen the other resources of society," he warns, "rather than to weaken the government."

—THE EDITORS



U.S. Naval Medical Center, Bethesda, Md.

*There's a place in the sun for*

## FEDERAL HOSPITALS

ELI GINZBERG  
Columbia University

THE previous articles<sup>1</sup> which reviewed the background and current trends of federal hospitalization emphasized that three major federal medical systems—those of the army, the navy, and the U.S. Public Health Service—had their origin in the late Eighteenth or early Nineteenth centuries, and have enjoyed steady development since that time.

At the end of World War I the fourth, and today the largest system, the Veterans Administration, was established. The most significant aspect of current trends in federal hos-

pitalization is the striking elevation of standards of care which has taken place since World War II in the hospitals of the Veterans Administration, and this progress was substantially paralleled in the general hospitals of the army.

During the past few years there has been considerable agitation to alter radically the structure and functioning of federal hospitals, an agitation in which many different groups have participated, for a variety of reasons, public and private. Attention can be called to the objections which leaders of organized medicine have expressed

to the armed forces' providing care to the dependents of service personnel; the repeated contention of the leaders of voluntary hospitals that in the future veterans should be cared for in community hospitals rather than in new hospitals constructed by the Veterans Administration; the insistence of critics of centralized government that the benefits now provided to veterans with nonservice-connected conditions are excessive and were never authorized by Congress.

Although these groups represent the most powerful critics of federal hospitalization, they have had allies in many experts who have reviewed the situation. Among the major criticisms presented by the experts are the fol-

<sup>1</sup>Ginzberg, Eli: Federal Hospitalization, I—The Setting, *Mod. Hosp.* 72:61 (April) 1949; and Federal Hospitalization, II—Current Trends, *Mod. Hosp.* 73:73 (August) 1949.

lowing: the care of patients with tuberculosis or mental diseases now provided by the federal government should be integrated with local and regional programs; there is no logic in the federal government's continuing to subsidize the building of community hospitals in various regions of the country which are in need of additional facilities and at the same time to proceed independently with an expansion of Veterans Administration hospitals, thereby undermining the very basis of regional planning; the medical departments of the army, navy, and air force are failing to concern themselves adequately with their major mission — planning for war—because they are preoccupied with furnishing medical care, including comprehensive hospital care, not only to service personnel but to their dependents; finally, the federal government is charged with gross inefficiency in the performance of its medical mission in that facilities are duplicated, excessive personnel is used, and specialists' skills are wasted, primarily because of the antiquated administrative structure which permits the uncoordinated operation of five (since the establishment of an independent air force) major federal hospital systems.

#### OBJECT TO QUALITY OF CARE

Some critics have found fault with federal hospitalization in still another respect—in the quality of care which federal hospitals provide. However, it appears that this particular charge is a carryover from the criticisms of conditions as they existed prior to World War II, when the Veterans Administration hospitals were below par and many other federal hospitals were providing only a minimum level of care.

In recent years the Veterans Administration has succeeded in having the deans of the leading medical schools assume major responsibility for the staffing and quality of care being provided in its important teaching hospitals; and the army has also succeeded in eliciting the cooperation of many distinguished leaders of American medicine in establishing and operating resident training programs in its major hospitals.

There are, undoubtedly, isolated hospitals currently operated by federal agencies in which the quality of care is not adequate, but on the average the level of care in federal hospitals today is superior to that of any other

system of hospitals within the United States. It is only necessary to contrast the federal hospital system with the other hospital systems—proprietary, municipal, and voluntary—in the richest state in the Union to substantiate this contention.<sup>2</sup>

The foregoing recital of criticisms of the present structure and functioning of federal hospitalization can be categorized under three major headings: scope, functioning and administration. The evidence adduced by the critics frequently transcends the limits of a single category, yet an appraisal of their arguments can best be made by keeping the categories distinct. The criticisms leveled at the present scope of federal hospitalization can be assessed by considering first those which relate to the provision of care to dependents by the armed forces, and then the more fundamental questions raised about the present and future operations of the Veterans Administration.

The attack on the armed forces' providing care for dependents is usually grounded in the claim that one way in which the gap between the available and the required number of medical personnel can be reduced is through a reduction in the patient load. It was feared some time ago that the armed forces would have to resort to a draft to meet their minimum medical personnel requirements. It seemed illogical to many to draft civilian doctors to care for the civilian dependents of service personnel. Further, it was contended that the provision of care to dependents was simply one method of advancing socialized medicine; for it implied that the federal government provided care at a nominal charge for large numbers of civilians. On occasion, the charge of unfair competition was advanced, usually by civilian physicians who resented the fact that the armed forces were taking care of individuals who otherwise would be their patients.

Since the armed forces must provide care for civilian dependents overseas and on isolated posts in this country for the simple reason that no suitable alternatives exist, the magnitude of the problem shrinks considerably. About 50 per cent of the million days of hospital care provided for dependents in army hospitals during the last year was care that the military had to provide. Since, further, the

provision of this care has been a traditional emolument of enlisted and officer personnel, a unilateral change must be considered in morals, if not in law, as a breach of contract.

It has been estimated that the provision of this care last year involved a cost of between \$10,000,000 and \$15,000,000 to the army. The proposal which has been made for the government to provide this care through insurance would represent a net cost to the army alone of more than \$100,000,000. Finally, the elimination of providing such care, instead of easing the medical personnel problems of the armed forces by reducing the patient load, would doubtless intensify the problem by reducing the attractiveness of a medical career and ensuring that those who did serve would become second-rate and third-rate doctors because of their limited experience.

#### CONCENTRATED ON V.A.

The Veterans Administration represents by far the largest sector of federal hospitalization, and it is not surprising therefore that the critics have concentrated their fire on its operations. In simplest terms, their argument is that it was never the intent of Congress to provide so much medical service for veterans with non-service-connected conditions. They emphasize the fact that in 1948 only 17 per cent of the total patients cared for had a service-connected disability. (On any one day the Veterans Administration is caring for two patients with a non-service-connected disability for every patient with a service-connected disability.)

It is sometimes contended that Congress has no declared policy with respect to the provision of medical care for veterans and that a policy should be formulated which would make only a limited number of veterans eligible for free care. In addition, some critics feel that the present unsatisfactory situation could be materially improved if serious efforts were made to have patients with non-service-connected conditions pay for their care to the extent that their resources permitted.

Congress has been legislating on veterans' benefits for three decades. Moreover, a review of the actions taken by Congress indicates very clearly that the legislators have been aware of the alternatives which have confronted them. This can be proved beyond a doubt by reference to the re-

<sup>2</sup>Ginzberg, Eli: *A Pattern for Hospital Care*, Columbia University Press, New York City, 1949, *Passim*.

stricting and then liberalizing actions which Congress took in the early 1930's in defining the categories of veterans eligible for care. A serious student of legislation would recognize that the members of Congress have been aware of the approximate ratio of veterans with service-connected conditions to veterans with nonservice-connected conditions in Veterans Administration hospitals, and yet with this knowledge have been willing to appropriate large funds for the building of additional hospitals.

It is true that Congress has avoided defining those eligible for care more specifically than stating that veterans with nonservice-connected conditions can be cared for if they are indigent and a bed is available. But the important point is that Congress has been willing to make more and more beds available. Regardless of whether one approves of the actions of Congress, it cannot be contended that Congress has had no policy.

#### SHOULD STUDY THE FACTS

The critics of the Veterans Administration would do well to study the facts. About 55 per cent of the present patient load in Veterans Administration hospitals are individuals suffering from mental disorders and an additional 15 per cent are suffering from tuberculosis. Since it is a fact that patients suffering from mental diseases or tuberculosis are usually indigent or become indigent shortly after the onset of their disease, they must be cared for by government.

To this 68 per cent of the patient load in Veterans Administration hospitals suffering from tuberculosis or mental diseases must be added another 4 per cent who are being treated for medical or surgical conditions which are service-connected. A patient admitted for treatment whose disability is classified as "nonservice-connected" may during the course of his hospital stay be reclassified "service-connected"; in fact such reclassifications take place constantly.

A still further adjustment is called for: Many patients being treated for medical or surgical conditions classified as nonservice-connected are actually suffering from long-term illnesses rather than from acute conditions; and ordinarily these patients would be cared for by government, for only the well-to-do can meet the expenses of a prolonged illness.

It would be well to consider whether

the hospital care currently provided by the Veterans Administration could be rendered under different auspices more efficiently or more economically. The leaders of the voluntary hospitals have indicated repeatedly in recent months their opinion that if the federal government is to continue to provide the present broad benefits to veterans, it should do so by purchasing this care in community hospitals rather than by building additional Veterans Administration hospitals. This seems like a reasonable proposal until it is recalled that only 8 per cent of the accumulated patient days in Veterans Administration hospitals is accounted for by patients with a duration of stay of less than 30 days, which are the type of patients conventionally treated in community hospitals! The Veterans Administration has repeatedly emphasized the specialized nature of its patient load but its critics continue to ignore this fact.

A more logical proposal would be to suggest that the states assume more responsibility for the care of veterans with mental diseases or tuberculosis; this has, in fact, been recommended by certain experts. In theory it would be desirable to integrate the care of veterans with care of other members of the community. And it is known that the treatment of tuberculosis and mental diseases entails much more than hospital care alone. The need is for a total program of case-finding, outpatient care, hospital care, and rehabilitation. But although the theory points in one direction, the facts point in another.

The quality of care being provided by local and state government throughout many parts of the United States for patients suffering from tuberculosis or mental diseases has been recognized by competent authorities to be strikingly inadequate. Congress is desirous of providing a good level of medical care for veterans suffering from these diseases, be they service-connected or not. But it cannot do this through reliance on the existing state or local hospital systems, at least in many parts of the country. Unless the Congress were willing seriously to entertain the prospect of raising the quality of care in many states—an extremely expensive and long-time undertaking—it would naturally attempt to provide such care within a system of federal hospitalization. Special note must be taken of the fact that the Veterans Administration is con-

stantly under pressure to remove those of its patients with tuberculosis or mental diseases who are currently being cared for in state hospitals, under a reimbursement plan, because of the pressure for admission to these institutions by individuals who are not veterans. Only major expansion and improvement of state hospital systems hold promise for the future.

#### MAY LEAD TO MAJOR ERRORS

Despite the apparent weakness of the critics' case, it would be wrong to conclude that progress lies along the path of building additional hospitals to be operated by the Veterans Administration. We may soon reach the point where the desire of Congress to be generous in the treatment of veterans who require medical and hospital care may lead to major errors in the allocation and utilization of our scarce medical resources. We know that the Veterans Administration has encountered serious difficulty in staffing several thousand beds in hospitals in isolated communities (a difficulty by no means limited to the Veterans Administration); and it would doubtless encounter similar difficulties in attempting to staff certain hospitals which the President, on the advice of the Bureau of the Budget, recently eliminated from its planning program. It is not surprising, however, that Congress has been skeptical about the evidence adduced by the Executive Branch which contended that a serious staffing problem would also be faced if hospitals were built or expanded in Detroit, Toledo, Cincinnati, Kansas City, Philadelphia, Pittsburgh, St. Louis and other large centers.

Since the system is approaching 150,000 beds, this may be a good point for the Veterans Administration to do what it can to check its further growth. Among the proposals which warrant consideration are the following: As occupancy in voluntary hospitals begins to decline, as it probably will in the well hospitalized regions of the country, the Veterans Administration might consider increasing the purchase of care for patients with service-connected conditions in hospitals which meet specified standards.

Inasmuch as the federal government is now caring for such a high percentage of veterans with tuberculosis or mental disease whose condition is not service-connected, Congress might contemplate the desirability of encouraging the states to expand their

hospital systems so as to care for veterans, for whom they would be reimbursed by the federal government. The problem would be much more difficult in those states where the present level of care is unsatisfactory. The federal government might, however, consider the establishment of special incentives to encourage these states to raise their standards.

In addition to these recommendations to reduce the scale of federal hospitalization and to alter the methods used by the federal government to provide services to various groups of beneficiaries, several proposals have been recently put forward to change radically the present administrative structure. The most far-reaching of these proposals was put forward by the Hoover Commission, which recommended (though not unanimously) the establishment of a unified medical service which would incorporate the hospital systems of the Veterans Administration and the Public Health Service, and almost all of the domestic hospitals of the armed forces.

This proposal was presented in the expectation that it would eliminate, or at least substantially alleviate, major shortcomings in the past and present operations of federal hospitals. It was predicated on the assumption that the medical personnel shortages confronting the armed forces would soon make it impossible for them to provide an adequate level of care. Unification would purportedly enable service personnel to be cared for in other federal hospitals which were more adequately staffed.

#### **PUT AN END TO COMPETITION**

Concerned about the large number of patients in Veterans Administration hospitals with nonservice-connected conditions, the commission's experts looked forward to an automatic reduction in the numbers that would be treated because the federal system would have to give priority to providing care for military personnel. The large number of empty beds in federal hospitals in various sections of the country and the duplication of major services, with the correlative under-utilization of specialists' skills, made a great impression on the commission. It was postulated by the majority of the commission that unification would put an end to competition among the several federal agencies and would result in a more eco-

nomical use of facilities and personnel.

The medical personnel shortages which pointed to a draft of doctors did not materialize; and the assumption that the medical services of the armed forces would flounder from a lack of specialists was also proved to be wrong. At the present time the Department of the Army is confronted with a necessity to adjust its training program because of a developing excess of specialists. From the recent behavior of Congress with respect to the Presidential cut-back of 16,000 beds in the building program of the Veterans Administration, the expectation that the amount of care provided to veterans with nonservice-connected disabilities would be reduced seems to have been groundless. The last Congress flatly refused to cancel the authority of the Veterans Administration to build these beds.

#### **NOT PROOF OF INEFFICIENCY**

The large number of empty beds in federal hospitals was not, as the commission believed, proof of inefficiency in planning on the part of the federal government; it was evidence of the rapid reduction in the scale of hospitalization in the armed forces after the end of hostilities. Most of these beds were in hospitals which had been constructed for the war emergency and were not staffed for current operations.

There were serious shortcomings in the administrative structure of the federal medical services, but it is questionable whether these shortcomings justified the radical proposal put forward by the Hoover Commission. It is an elementary principle in the theory of administration that every change, regardless of its potential benefits, involves costs because the prevailing pattern must be disrupted. A second basic principle warns against the expectation of accomplishing significant substantive results through administrative changes alone. A third principle recognizes the desirability of introducing a series of reforms in stages to avoid irremediable errors and to benefit from experience.

A reform in the administrative structure of the federal medical services is definitely desirable. Until very recently the medical departments of the army and the navy operated completely independently of each other, and an inevitable duplication of facilities and personnel resulted. Mr. Forrestal took the first steps to coordinate their activities and, more re-

cently, Mr. Johnson has expanded the mechanisms to ensure that the basic policies of army, air force, and navy with respect to medical operations be coordinated and, to the maximum extent possible, unified. (In large part, the criticisms levied by the Hoover Commission must be credited with stimulating these actions by the Department of Defense.)

It is well to emphasize that the degree to which medical operations can be unified within the armed forces depends on the degree to which the armed forces themselves are unified. All too frequently, civilian critics overlook the fact that the medical departments of the army, air force, and navy have as their first responsibility the support of the basic mission of their respective Force. Joint use of facilities, joint staffing, integrated procurement operations are realities. The next stages involve a higher degree of joint planning and joint training. But there can be little doubt that a major sector of duplication and waste in the operation of the federal medical services is now being brought under reasonable control by the progress which is being made to coordinate the medical work of the armed forces.

#### **NO COORDINATING AGENCY**

At present there is no coordinating agency charged with maximizing the use of the medical facilities and personnel available to the armed forces, the Veterans Administration and the U.S. Public Health Service. Coordination exists, but it proceeds on an informal basis and consists primarily of the army's and navy's granting bed credits to the Veterans Administration. It would clearly be constructive if a higher degree of coordination were developed among the major agencies so that their combined resources could be utilized to a maximum. For instance, it might be desirable for the armed forces' procurement system to purchase medical supplies for the other federal agencies. The beginning of coordination would be the establishment of a formal coordinating agency which could determine the measures most likely to lead to increased efficiency.

The Federal Medical Services Task Force of the Hoover Commission emphasized the absence of a top-level supervisory and planning agency concerned with appraising the relationships within federal medicine and between federal medicine and the civi-

lian medical economy. The Federal Board of Hospitalization which has recently become defunct failed to perform this essential mission, and the fiscal preoccupations of the Bureau of the Budget make it unlikely that this agency, as presently constituted, can fill the gap. However, the gap should be filled, and the sooner the better, for an operation of the magnitude of the federal medical services, which currently exceeds an annual expenditure of more than one billion dollars for operating purposes, has need for a planning agency of the highest quality.

This review of the present status and future prospects of federal hospitalization points to a few major conclusions. The system is currently operating at a level which must be adjudged to be more than adequate, especially if primary consideration is given to the quality of hospital care

and even to the costs of providing such care once allowance is made for the fact that the federal costs include payments for physicians' services. In light of this judgment, there is no justification whatever for introducing radical changes into the system since such changes are more likely to be destructive than constructive.

There is reason to question the indefinite expansion of the Veterans Administration's hospital system, and consideration should therefore be given to the desirability of the federal government's developing a long-range plan to purchase care in community, state, and local hospitals when these meet prescribed standards. In those states where the existing level of care for patients with tuberculosis or mental diseases is inadequate, it might be desirable for the federal government to make special incentives available so that a proper level of care can

eventually be provided to all citizens, including veterans. From an administrative point of view, the major shortcoming is the absence of adequate coordinating and planning agencies to ensure the maximum utilization of the medical resources of the federal government.

Critics of the federal government frequently forget the basic fact that the expansion of federal operations is almost always a reflection of a failure of individuals, voluntary effort, local and state government to provide for essential needs. Those who are truly concerned about the indefinite growth of the federal government must act to strengthen the other resources of the society rather than to weaken the federal government.

This third and final article of a series by Dr. Ginzberg deals with federal hospitalization policies. Earlier articles reviewed the history of federal hospital systems and discussed current hospital trends.

## A.M.A. Trustees Repudiate the "Hess Report"

### Ask delegates to rescind approval

CHICAGO. — The Board of Trustees of the American Medical Association said here last month that the "Hess Report" approved by the association's House of Delegates last June is, in the opinion of the board, "illegal and contrary to previous court decisions." The Board will ask the House of Delegates in its December meeting at Washington, D.C., to rescind its adoption of the report—officially a recommendation of the association's Committee on Hospitals and the Practice of Medicine.

In its annual report to association members published in the *Journal of the American Medical Association* for November 5, the Board quoted an opinion of association's legal counsel acknowledging that the committee "merely meant to see to it that the members of the American Medical Association abide by the principles of medical ethics . . . properly and lawfully construed and applied." Referring to that part of the committee's report recommending that the Judicial Council of the A.M.A. should order with-

drawal of association approval of hospitals found guilty of unethical practice, trustees quoted counsel as stating, "there is, however, language in said report that could be seized upon by a person or party so disposed, in argument to court or jury, that it was the purpose of American Medical Association to unreasonably restrain, coerce or conspire against some particular hospital or institution and not merely to enforce the principles of medical ethics . . . in a lawful manner."

The trustees' report said that the opinion of counsel "supports the Board's own view that the action of the House of Delegates . . . is illegal and contrary to previous court decisions and also supports the Board's own opinion that to activate the recommendations of the report would be unwise. The Board of Trustees therefore requests that the House of Delegates rescind at the earliest possible moment its adoption of the report of the committee on hospitals and the practice of medicine."

As reported in the July 1949 issue

of *The Modern Hospital*, the committee, in addition to recommending the establishment of state groups to study and adjudicate hospital-physician controversies, had recommended that disputes which could not be resolved by local and state agencies should be brought to the association's Judicial Council for examination. "If the Judicial Council cannot adjudicate the specific matter and finds ethical and legal compromise impossible," the committee recommendation read, "then suitable action should be taken against the physician or institution found guilty. If a hospital or other lay group is found guilty and will not cooperate within ethical and legal limits, it is recommended that the judicial council shall order the withdrawal of the association's approval of that institution."

An earlier section of the report had specified "that it is illegal . . . and unethical for any lay corporation to practice medicine and to furnish services for a professional fee which shall be so divided as to produce profit for a lay employer, either individual or institutional (hospitals and medical schools)."

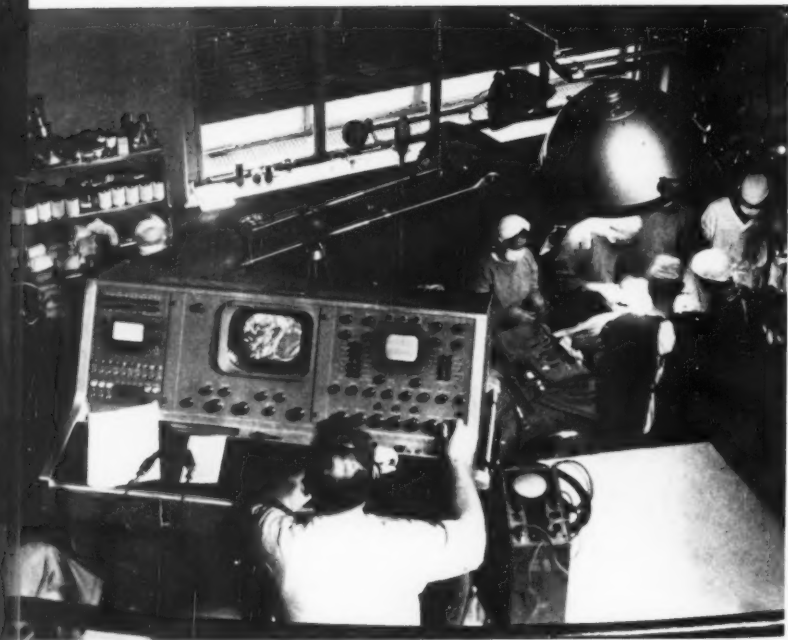
# EXIT—the Surgical Amphitheater

CARL A. ERIKSON JR.  
Schmidt, Garden and Erikson  
Architects  
Chicago

ST. LUKE'S HOSPITAL has just participated in the third presentation of color television of surgical operations. For five successive days, operations in a surgical amphitheater were transmitted seven blocks away to a series of receivers set up in the lounge of a Chicago hotel, where several thousand members of the American College of Surgeons viewed surgical technic as if it were literally being done in their laps. As many as 500 doctors at a time watched the various procedures that were televised, using several receivers.

Each surgical field seen in color was enlarged about one and a half to two times and was accompanied by the broadcast voice of the surgeon describing his work. The operative field seen in color was real and vital; the perspective and definitiveness brought out detail seen heretofore only by the surgeon. Operations televised ran the gamut of modern surgery, including brain surgery, removal of a gall bladder, and the removal of a lung; the only limitations seemed to be such technics as a bronchoscopy or a prostatectomy where the surgical field cannot be seen directly, even by the surgeon.

The color television was designed and built by the Columbia Broadcasting System, Zenith Radio Corporation and Webster Chicago Corporation for Smith, Kline and French, which has made the color television debut as a contribution to medical education. The color television transmitting equipment consists of the camera and a control desk. The televised picture is focused and the color content is mixed at the control desk. (See figure 1.) The camera is mounted on a tripod not unlike that of a portable operating room light as shown in figure 2. The camera is usually placed about 4½ feet from the operating field. The control desk was mounted on a platform 6 feet above the floor and built over the first two steps of the elevated amphitheater. This latter stands as a symbol of a



Photographs by Inez M. Porter, St. Luke's Hospital, Chicago.

Fig. 1 (above): The color content of the picture is mixed at control desk.

Fig. 2 (below): The camera is mounted on a tripod (left foreground).



# ENTER—Television

**ROBERT F. BROWN, M.D.**

Medical Director and Assistant Administrator  
St. Luke's Hospital, Chicago  
Lecturer, Program in Hospital Administration  
Northwestern University

ghost of by-gone days—an attempt to teach surgery by "long-distance viewing." A modern operating room light furnished sufficient illumination; care was used to select a source of white light which gave no color accent.

During the televising, Dr. Kendall A. Elsom, associate professor of medicine at the University of Pennsylvania, served as coordinator and announcer. The technical crew from the Columbia Broadcasting System consisted of a cameraman who trained the camera on the operating field, a monitor (color mixer) at the control desk, and an audio engineer who was responsible for the sound transmission. Another crew stood by the 18 receivers in the hotel to monitor the receivers and check the synchronization of the color disks.

The color television is the sequential type which operates like black and white television. Each element of the picture is transmitted in detail, frame by frame, in rapid enough succession so as to present a complete image to the human eye. The color transmitted represents successive pictures of red, blue and green images, each lasting  $1/150$ th of a second and following each other in this rotation at intervals of  $1/50$ th of a second. Owing to the retentiveness of the human eye, the individual sees a composite image identical in color to the surgical field being televised. Both the color television receiver and the camera contain a rotating color disk; the synchronization of these rotating disks produces the color in the images. It is stated that the equipment is essentially no more complex than black and white television. Therefore, we can conclude that color television is on our doorstep!

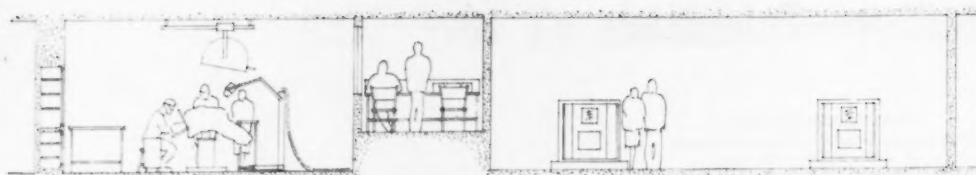
The first color television presentation of the "Teaching of Hospital Procedures Other Than Surgery" was performed by the administrative staff of St. Luke's Hospital. This program was set up in two sections as shown on page 51.



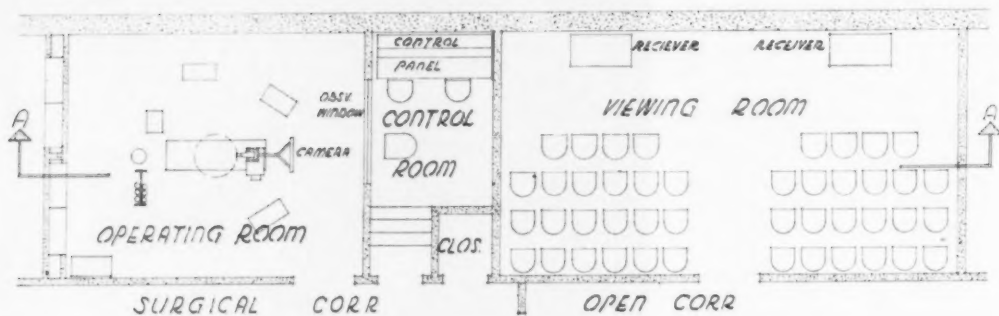
Fig. 3. (above): Perspective shot showing position of the control desk.

Fig. 4 (below): Preparation of the instrument setup for an appendectomy.

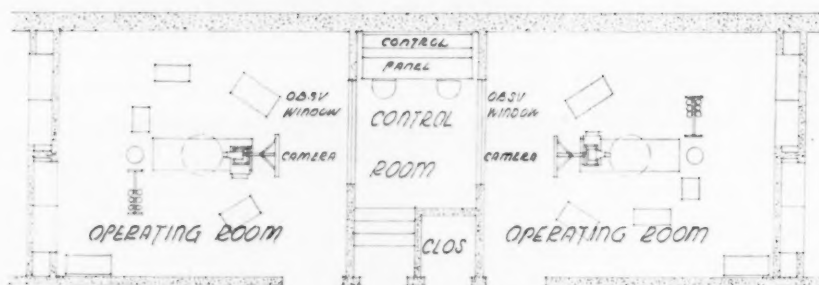




ELEVATION "A-A"



VIEWING ROOM WITH CONTROL & OPERATING ROOMS  
ADJOINING



CONTROL & OPERATING ROOMS ADJOINING  
VIEWING ROOM REMOTE

Two possible medical television setups by Schmidt, Garden and Erikson, architects. At the top is an elevation showing the interior of the operating room, control room and viewing room. Center: The first plan in which a small control room is established between an operating room and a viewing auditorium. Bottom: In the second plan, the control and operating rooms adjoin. The viewing room could be located elsewhere on the same floor or at some even more remote section of the building.

## PART I

1. Preparation of the instrument setup for an appendectomy in the operating room at St. Luke's Hospital.

Selection of instruments.

Sterilization of instruments.

Procedure for scrubbing of hands, gowning and gloving.

Setting up room for an operation.

Duties of scrub nurse.

Duties of circulating nurse.

## PART II

1. Preemployment interview.

2. Presentation of "on-the-job" training program, carried on in the dietary department of St. Luke's Hospital.

3. On-the-job training.

4. Serving a food tray to the patient.

5. Progress report or merit rating of dietary department employee.

Our respect for television directors mounted to untold heights. A surgical operation, once started, followed through uninterruptedly under the talents of the skillful surgeon; the administrative program represented the combined effort of individuals with no dramatic or acting experience. The plan of the program was rehearsed by careful drilling. The scene shifting reminded one of "behind the stage" actions in a high school play. The dialogs were not memorized but the actions were carefully planned. The results indicate that there is a rôle for television in the teaching of hospital administrative techniques as well as those of surgery. In nursing, especially, television will enable students to observe details, such as methods used by the scrub nurse, that are ordinarily lost to view. Too, it will permit hospital administration students to "enter" areas, such as the operating room, where they are not now taken.

At the end of the demonstrations, all the participants had reached the same conclusion: "A new teaching medium has been developed" which can profoundly influence all education—particularly the fields of postgraduate surgery, nursing and hospital administration.

Dr. Malcolm T. MacEachern prophesies, "I foresee surgical technic performed in Chicago televised to medical meetings and medical schools from New York to Los Angeles and, for that matter, to many other medical centers throughout the world."

Madeleine McConnell, director of the school of nursing and nursing

service, St. Luke's Hospital, exclaimed at the conclusion of the administrative color television program, "There is a definite place for color television in nursing education. The addition of color to television has developed a medium which represents the highest perfection in visual education."

Dr. Foster L. McMillan, chairman of the department of surgery and chairman of the television committee at St. Luke's Hospital, and associate clinical professor of surgery at the University of Illinois Medical School says, "Color television will be of great importance in the field of postgraduate surgical education."

Carl A. Erikson Sr. of Schmidt, Garden and Erikson, hospital architects, says, "The simplicity of color television devices and their mobility would make television ideal for instructional purposes in hospitals."

Amphitheaters of many sizes, shapes and arrangements can be found in hospitals of this country. Small glassed-in rooms elevated slightly to the side of or nearly overhead of operating tables are found in recently constructed operating rooms. Some of these are equipped with "talk-back" sound systems for contact between the "watchers" and the surgeons. Several older hospital buildings contain gargantuan-like steps which rise in tiers to heights of one, two or even three regular rooms on which student "watchers" peer many feet toward a surgical operation below. Even the

modern smaller amphitheaters have been found to be of limited use because the human eye just cannot see detail at such distances.

With the advent of color television, an enlarged field in full detail and full color can be placed directly in front of the student. Where formerly he could see little or nothing, he will now be able to see all. Communicating audio equipment between the surgeon and his students can be easily provided. Furthermore, the size of the audience can be larger when several receivers are used in the viewing room.

Two possible operating room plans are presented as practical arrangements. In one case, a small control room would be established between an operating room and a viewing auditorium as in plan 1.

The second plan provides two operating rooms with a control room between. In this case, the viewing room would be placed elsewhere on the same floor, on the floor above, or on the floor below—or for that matter, at a more distant location.

With the development of a color television transmitter which can be entirely contained in the base of the camera tripod, the control room can be omitted entirely. The problem then resolves into one of furnishing electrical power for the equipment and transmitting lines between the operating rooms and the viewing rooms.

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## Administrative Capsules

THERE ARE MANY THINGS THAT you can do for a patient in his home that you cannot do for him in a hospital, and vice versa.

HOSPITALIZATION DURING ILLNESS, or institutionalization at any other time, is a misfortune for some people and a calamity for others. It is often humiliating and sometimes degrading. Here may be found the strongest argument for an extramural hospital program.

THE OBLIGATION of the hospital does not end with the emergency.

THE PATIENT who is admitted to the wards of a hospital for social rather than for medical reasons is often the most difficult of patients to discharge, and for the same reasons.

THE DOCTOR must stick tenaciously to his unsolved problems and never let go of them, much less isolate and segregate them at a distance from his clinical and research laboratories in the modern hospital when the patient needs his services most.

YOU DON'T NEED X-RAY EYES to look through a hospital wall nor do you need military genius to overcome such an obstacle when an inexpensive bed in the patient's home beyond the wall stands ready for hospital use.

—E. M. BLUESTONE, M.D.

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# The Formula Unit Appeals To Father

**Genesee Hospital makes its formula unit serve two uses: simplifying production, and improving public relations**

**EDGAR L. GEIBEL**  
Assistant Director  
Genesee Hospital  
Rochester, N.Y.

THE basic design of this formula making unit evolved around our desire to: (1) design a unit around a work flow chart; (2) create a single unit capable of producing formulas for at least 50 infants where all the work could be performed by one person; (3) utilize a minimum of custom-made equipment; (4) improve our public relations through a visual display of the unit for the benefit of the new fathers and grandparents.

In contrast to those who believe that the formula room should be located in an area remote from the patient area, we believed it should be on the maternity corridor which leads directly from the main corridor. The rooms assigned to this unit were formerly supply rooms and were completely remodeled by the hospital maintenance department.

## EVERY VISITOR SEES IT

The location is such that every visitor to a patient in the maternity wing must pass along the corridor outside of the formula rooms. Figures 1, 2 and 3 provide a view of what the visitor sees from the corridor. The generous use of glass in the doors and the refrigerator encourages a closer scrutiny by the visitor.

With the idea of further encouraging observation and attracting the eye of the father or visitor, metal card holders bearing the last name of the infant are hung on the rack of the refrigerator shelf, back of which rests the intended formula for that particular infant. Fathers invariably pause to look and admire their names on the tags and the names of the associates of their newborn child. Because the unit has eye appeal, the visitors' attention is attracted and a close inspection makes them more cognizant of the hospital's effort to provide a safe formula.

Generally, all equipment is of

standard make or has been modified to suit our purposes. The only exception is a stainless metal sink in the preparation room, which was custom made. In the bottle washing room, a standard three-compartment stainless metal bar sink has been modified by increasing the size of the splash board to a height of 12 inches and lengthening the supporting legs to raise the sink to a working height.

A standard white enamel kitchen cabinet in the washing room holds all the cleaning gear. A standard electric glass washer which fits into one of the sink compartments has been modified by a brush capable of washing the wide-mouthed nursing bottles.

A home-made bottle rinsing unit (over-all size 10½ by 8 by 6 inches) consists of 12 compartments into which the washed bottles are inverted and sprayed with hot tap water from small jets. This is a modification of the idea presented by Dr. A. J. J. Rourke in *Hospitals*, June 1947.<sup>1</sup> A flick of the wrist activates a standard flush valve which provides an automatic 10 second rinse of each bottle.

Home-made wooden bottle cases holding 25 bottles are stacked on portable dollies which serve as storage containers for the empty clean bottles. A standard stainless metal utility cart serves as a vehicle to move filled bottles from the autoclave to the sink and from sink to refrigerator. A standard white enamel kitchen cabinet in the preparation room serves as storage space for formula ingredients and preparation materials. Storage space has been limited to a minimum on the theory that excess space encourages the accumulation of unnecessary items. The stainless metal sink in the preparation room serves the dual purpose of washing and also as a water bath.

Since few formulas require the use

of a hot plate, a one-burner electric hot plate was selected for the reason that it could be moved out of the working area when necessary. All mixing is done with the aid of an electric blender.

The refrigerator is a standard stainless metal model in which the manufacturer has provided double entry doors. The refrigerator with sliding glass panels, à la supermarket, on the corridor side sets in the wall and has two conventional doors on the inside of the preparation room.

The table tops are plywood with plastic surfaces and were fashioned by the hospital maintenance department. Supporting braces were designed to extend from the table top to the baseboard rather than to the floor. This provides for easier cleaning and increased safety.

Immediately after the formulas are consumed by the infants, the bottles are rinsed with cold water. The empty bottles collect in the bottle washing room until noon of each day. Bottle washing is performed only in the afternoon.

## INNER SURFACES RINSED

The bottles are washed in the mechanical bottle washer in the first compartment of the sink. They are then rinsed in flowing water in the second compartment and receive a final rinse in the bottle rinsing rack in the third compartment. The operator presses the flush valve and the inner surfaces of the bottles are automatically exposed to a 10 second rinse with hot tap water.

Emphasis is placed upon careful cleaning of the bottles, their component parts, and all soiled utensils. Terminal heating procedures do not replace careful cleaning methods. Following the hot rinse, the bottles are lifted out of the rinsing rack and are placed in an inverted position in a miniature milk case which holds 25 bottles. The case is then pushed along

<sup>1</sup>Rourke, A. J. J.: *Infant Formulas*, 2. *Preparation Techniques*. *Hosp.* 21:66 (June) 1947.

the table top and an empty case is placed on the drainboard to receive more freshly washed bottles.

As the cases accumulate along the table top, they are pushed through the pass window into the preparation room. After the filled cases arrive in the preparation room, they are lifted from the table top and placed on small wooden dollies. The dollies were constructed to permit the stacking of three cases and still allow the finished unit of three cases to slide under the table top and out of the way. Here, they remain until the following morning when they are all ready for use by the formula room worker.

Formulas are prepared in bulk depending upon the demand for Stock Formula No. 1, No. 2, or No. 3. The majority of all formulas prepared fall within the stock formulas. This standardization of infant formulas has permitted mass production with an increased worker efficiency. The three stock formulas were determined by a committee of the hospital pediatric staff, and recommended to the members of the pediatric and obstetrical departments.

To encourage the use of the stock formulas, a formula prescription form was devised which requires a minimum of writing by the medical staff. The physician writes the name of the infant, two numbers and his name. One number indicates the number of feedings per day and the other number indicates the quantity to be received by the infant at each feeding. Additional space on the form is available for requesting a special formula other than a stock formula if the physician so desires. Generally, the three stock formulas meet the demands of most of our physicians.

After the formulas are bottled, the nipple assemblies are placed on the bottles and are covered with a rubber hood. Racks of eight-bottle capacity are placed in the autoclave. The formulas are then processed at 230° F.

(approximately 7 pounds) for 10 minutes.<sup>2</sup> This method for the terminal heating of infant formulas has consistently produced relatively sterile samples with adequate results. At 230° F., a barely discernible browning has occurred but has not been sufficient to warrant a single criticism in six months of operation. At this temperature, Hodson<sup>3</sup> doubts that any significant loss of the more heat-stable nutrients of milk occurs during the terminal heating of infant formula.

After the formulas have been subjected to 230° F. for 10 minutes, the steam is shut off and the pressure is reduced very slowly. This slow reduction of pressure has successfully prevented nipple clogging resulting from the boiling over of formula when too rapid exhaust of pressure takes place.

Upon removal from the autoclave, each rack of bottles is immediately placed in a water bath for 10 minutes. The stainless metal sink in the preparation room serves as the container, and the cooling agent is cold tap water. The sink has an overflow outlet 4 inches above the floor of the sink which permits a constant flow of water and prevents the water from contaminating the nipple assembly.

Following the cooling process, the bottles are checked for corrected closure and nipple cover. The bottle bottoms are dried and the completed formulas are placed in the correct rack in the refrigerator.

At the time the infant's formula is bottled, the name is written on a ground glass portion of the bottle. A half-inch high partition, the width of a bottle, extends the depth of the refrigerator. Each partitioned section

of the refrigerator shelf is identified by hanging name tags at both ends of the section inside the refrigerator. The name on the bottle must correspond to the name tag hanging on the shelf.

When the first formula prescription for a newborn is received by the formula room worker, one and one-half times the number of feedings are automatically bottled. If a change in formula is requested during the infant's hospital stay, all the formula remaining in the partition in the refrigerator is discarded and one and one-half times the number of feedings of the new formula are made up. The partitions on the refrigerator shelf prevent the mix-up of old and freshly prepared formulas, the oldest formula always being closest to the corridor side of the refrigerator.

With this design, formula room traffic is reduced to a minimum. There is no necessity for anyone other than the formula room worker and the cleaning maid to enter the preparation room. The nursery nurses obtain the formula from the corridor side of the refrigerator and have no reason to enter the preparation room.

Actually the cost of construction of the unit is unknown. We started with all the walls in place and plumbing lines available in each room. With this as a starting point, we expended \$4000 for equipment and materials. No effort was made to place a money value on the labor performed by the maintenance department. For this reason, the total cost of the unit as it is today is unknown, although a fairly reliable estimate could be determined.

The first six months' operation has indicated that we will be able to anticipate a savings in the labor cost of the formula room of approximately \$1000 per year.

P.S. While this unit is the creation of the author, credit for its actual execution is due to the Genesee Hospital maintenance department under the direction of Sanford Cronk, chief engineer.

Fig. 1 (left): Corridor view with completed formulas on display to show Proud Papas that their offspring are being provided with safe formulas. Fig. 2 (center): Bottle washing room. Fig. 3 (right): Preparation room.



<sup>2</sup>Finley, R. D., Smith, F. R., and Louder, E. A.: Terminal Heating of Infant Formula. 2. Bacteriological Investigation of High-Pressure Technique. *J. Am. Dietet. A.* 24: 760, 1948.

<sup>3</sup>Hodson, A. Z.: Terminal Heating of Infant Formula. 3. Retention of Heat-Stable Nutrients. *J. Am. Dietet. A.* 25: 119, 1949.



**Herrick Memorial Hospital is**

## **READY FOR ALL EMERGENCIES**

**ALFRED E. MAFFLY**

Administrator  
Herrick Memorial Hospital  
Berkeley, Calif.

**HENRY X. JACKSON**

Assistant Administrator  
Herrick Memorial Hospital  
Berkeley, Calif.

**E**VERY community needs certain standby services for the protection and convenience of its residents. Among these are police protection, fire protection, emergency hospital and similar services.

All these services must be maintained on a standby basis, constantly available and completely manned throughout the entire 24 hours of every day (365 days a year). They must be ready for every eventuality, large and small, and must be prepared for immediate expansion in case of a large-scale disaster or other extraordinary occurrence.

Like fires, accidents occur at all hours. It is not reasonable to expect every doctor to be constantly available to care for the injuries that may occur

to his patients; for that reason, emergency hospitals are maintained to give first aid and emergency care at all hours to sick or injured people and then to refer them to their family doctors for further care.

Some large cities, like San Francisco, have set up detached emergency hospitals at strategic points throughout the city. It is an expensive procedure to maintain such highly specialized emergency units completely manned on a 24 hour basis, particularly now that the 40 hour week is universally established. Under the 40 hour week, it must be remembered that it takes five people to man each individual post for the 168 hours in each week.

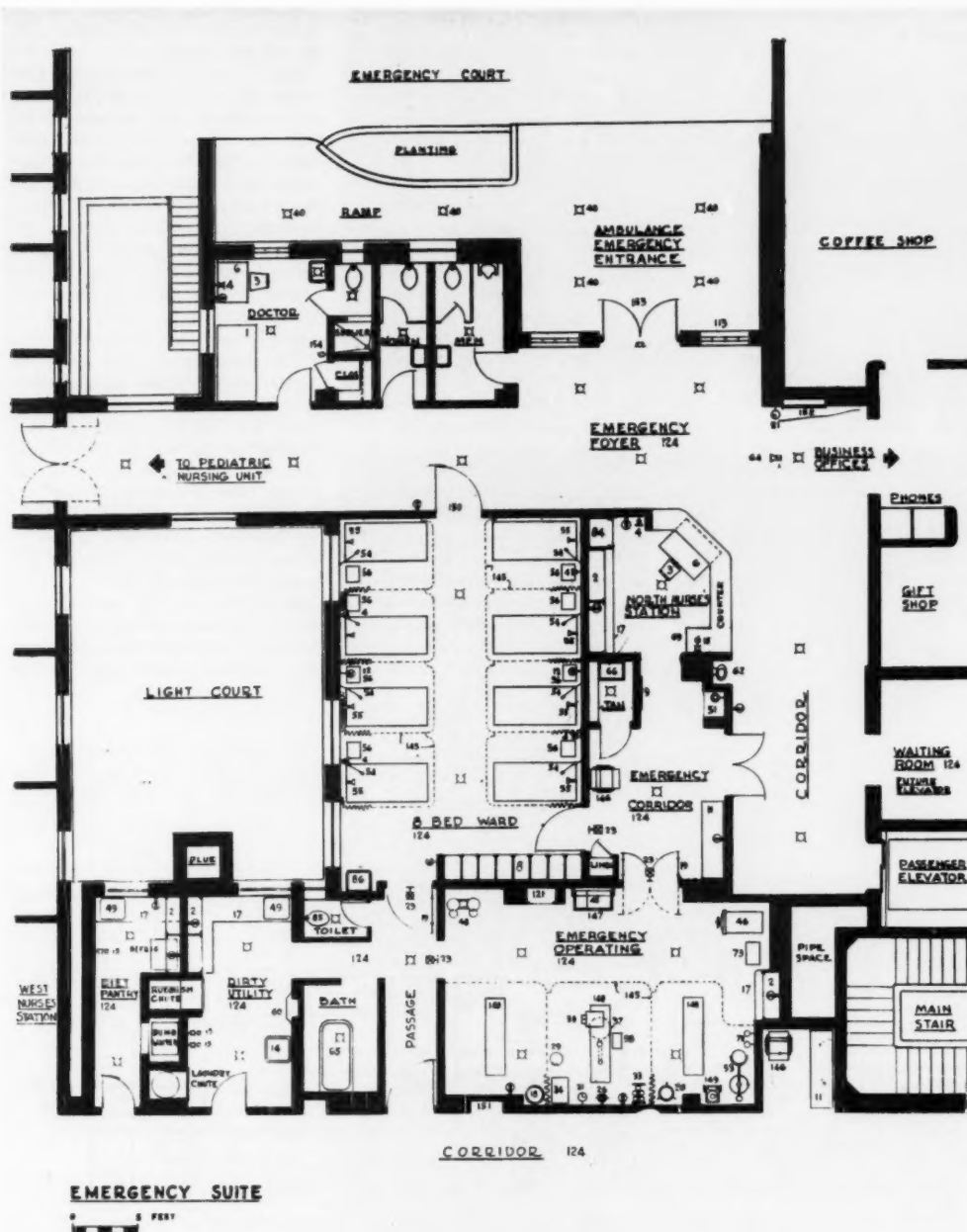
Most smaller cities have found it far more practical and far less expensive to maintain the emergency hospital as a part of a general hospital. Such is the case in Berkeley, Calif.,

where the city supports its emergency hospital at the Herrick Memorial Hospital, which is located in the center of the city about three blocks from the city hall and the police station.

This hospital was designated as the emergency hospital for the city in 1909 and has almost 40 years of background in this field. It is of historical significance to note that one of the first contracts drawn by the new city government when it was first organized, Contract No. 7, in fact, was for the establishment of this emergency hospital, indicative of the early recognition by the city fathers of the importance of emergency hospital service.

In a general hospital, the various departments which might be utilized in the treatment of emergency patients are already set up and geared for a relatively heavy inpatient load.

Presented at the American College of Surgeons Clinical Congress in Los Angeles, October 1948.



Floor plan of the emergency suite. Starting on the north with the ambulance emergency entrance, the patient moves to the nurses' station; is then routed according to his condition and indications for treatment to the emergency operating room for treatment, to the recovery ward if in violent shock, in some cases to the waiting room or directly to surgery. The convenience of the utility room, bath and toilet facilities and emergency equipment all contribute to ease of handling. Note location (across north corridor) of doctor's room and public toilets.

The time of the personnel in a purely emergency setup is rarely used to capacity, whereas in a general hospital those people can be performing other duties between cases. Less money will be tied up in equipment and supplies in the general hospital, for the same supplies will be stocked for other departments. Regardless of the type, however, the residents of the community will expect, and rightly so, that an efficient service for the treatment of emergency trauma and illness be maintained.

Emergency hospital service starts at the scene of the accident with the emergency ambulance and the ambulance attendants. In Berkeley, emergency ambulance service is a function of the police department. The city has constantly available two excellent and well equipped emergency ambulances which are manned by police officers well trained in first aid procedures and in the proper and safe transportation of accident victims from the scene of the accident to the emergency hospital.

The use of policemen as ambulance stewards eliminates the need for setting up a duplicate municipal ambu-

lance service. The police ambulances also are used as patrol wagons. The combining of the police patrol and emergency ambulance services affords great savings in cost of operation and avoids the needless duplication occasioned when these services are maintained independently.

### Staffing the Department

The prime requisite for a well run emergency service is the immediate availability of medical attention once the patient reaches the hospital. For this reason serious thought should be given to selection of the personnel that will staff the department. The size of the hospital and the makeup of its medical staff will largely determine the nature of this selection.

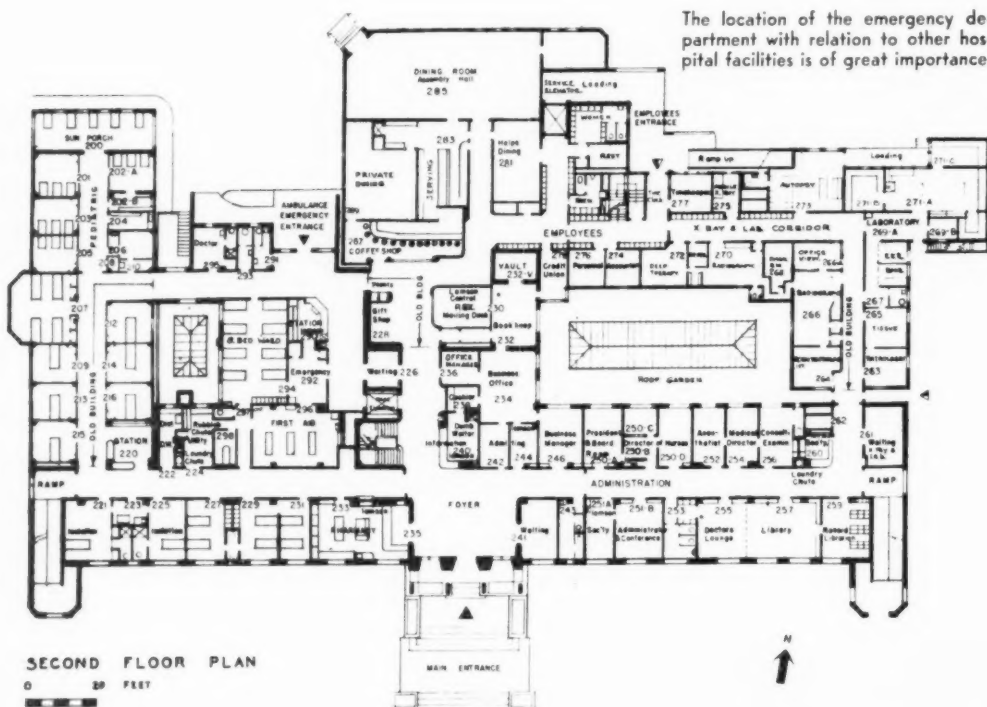
The ideal situation is one in which a sufficient number of interns and residents is available for assignment to the service on a 24 hour basis. Where this method is used, an attending physician should supervise the work and hold himself available for consultation and for the handling of serious cases. For the vast majority of hospitals which conduct no such educational program, a very satisfactory

arrangement can be worked out by using members of the medical staff for alternating duty.

Such a system is presently in effect at Herrick, although it is planned to use the interns and residents for at least one of the shifts in the near future and, if that proves satisfactory, eventually to have them conduct the entire emergency service under proper medical supervision. A panel of 24 doctors now rotates on eight-hour shifts, so that each serves once in eight days. Replacements are suggested by the chief of the service and are appointed by the governing body.

The consideration which moves the doctors to participate in the emergency service must be one based primarily on a desire to serve the community. At Herrick the doctors provide their services at no cost to the patient. The community service purpose of the department and the prestige and medical experience gained by serving on the panel is adequate compensation for most doctors.

In addition to the medical staff, there must be a nurse on duty 24 hours a day to receive patients, prepare the emergency record, notify relatives



The location of the emergency department with relation to other hospital facilities is of great importance.

and family doctors, and assist the doctor in the treatment room. It is also her duty to observe and care for the patients in the recovery ward, to notify the police and coroner, when indicated, to handle press relationships for all emergency cases, and to see that supplies and equipment are kept up. She must be a person of unusual tact, sympathetic yet firm, possessed of unlimited patience, alert and competent.

While these qualifications may seem far-reaching, those who know the unpredictable reactions of overwrought relatives will realize the necessity for each in the maintenance of good public relations. It is important that the administration exercise control over the policies and procedures governing the emergency service. To ensure uniformity, a procedure book has been developed for the guidance of the emergency nurse and doctors.

### The Emergency Committee

While it is recognized that in the actual treatment of patients, the medical judgment and the ethics of the attending doctor will govern the course to be followed, some degree of control must still be maintained if the hospital is to be well represented by its emergency staff. We have found that the most effective method of reaching a meeting of the medical minds of the panel is through an emergency committee composed of members of the medical staff and a representative of the hospital administration.

A manual should be written or adopted which sets the medical standards for the group and which outlines the emergency treatment for any specific diagnosis or syndrome. The emergency committee at Herrick has adopted two texts as reference: (1) "A Manual of Medical and Surgical Emergencies" by J. C. Geiger, M.D., director of the Department of Public Health for the City and County of San Francisco; and (2) "Official Directory of Antidotes," California State Board of Pharmacy.

This committee serves in the same liaison capacity between the panel and the hospital as the medical advisory board serves between the medical staff and the hospital. To it are referred all administrative problems arising from the treatment of emergency patients. There is often some dispute as to where emergency care ends and private practice begins; there is sometimes a question of ethics involved, as for example when the doctor fails to reach



The receiving dock should be at the same height as floor of ambulance.



A view of the treatment room taken from the emergency nurses' station.

Nursing care in the eight-bed recovery ward is given by emergency nurse.



the family physician for notification; here, allegations of careless work are investigated.

Another important function of this group is to bring to light and discuss new methods of treatment and new equipment that might be used to advantage. At each of the monthly meetings a short scientific presentation is made by one of the members, and recent pertinent literature is reviewed.

### Financial Aspects

The cost of the emergency service has constantly risen along with other hospital costs. At the present time at Herrick it is \$3.02 per emergency patient treated, exclusive of the value of medical care, which is donated. The direct costs of operation, such as salaries, cost of supplies consumed, and even such indirect costs as apportionment of overhead, depreciation and so on, are readily determined.

Although patients are not charged for the emergency service, they are charged should any services be rendered beyond first aid and emergency care. Revenue is also derived from compensation and other insurance carriers and from city contracts. To these figures must be added the income from such other departments as x-ray, laboratory and surgery where these facilities have been used for emergency patients.

In any system comparable to that used at Herrick, it can be assumed that the operating statement of the department will show a deficit, inasmuch as the majority of the care rendered will be done with no charge to the patient. The income from other departments utilized in the care of emergency patients will tend to minimize the deficit.

Many cities, recognizing in the maintenance of an emergency service a direct contribution to the welfare of its residents, will assume all or a portion of the remaining deficit. Such payments may be made in many ways: (1) through a per capita reimbursement; (2) through a reimbursement of a percentage of the expenses incurred, or (3) through the payment of a fixed annual sum. Herrick Hospital is reimbursed on the third basis as outlined in the contracts between the cities of Berkeley, Oakland and Albany and the hospital.

### Inherent Dangers

There are certain inescapable hazards connected with the maintenance of an emergency hospital service. Chief



among these is the ever-present possibility of the development of unfavorable relationships with the public and with the medical profession. An unsympathetic attitude on the part of the nurse or the doctor, an unavoidable delay of even a few minutes, undue concern for the payment of a just bill, the death in the hospital of an already moribund patient—any of these is likely to start an avalanche of adverse criticism against the hospital, and in some cases actual suit. It should be mandatory for all doctors to carry ample malpractice insurance as a protection against legal involvement.

The other medical men in the community will be constantly on the alert for any sign of "patient-stealing," real or imagined, and will charge that the hospital is rendering free service which should be done in their private offices. Some will cast aspersions on the quality of the care given in an attempt to divert their patients from future treatment at the hospital. Every effort is made at Herrick to refer the patient to his own family doctor for follow-up care. To encourage this a rubber stamp is placed on all dressings stating:

THIS IS AN EMERGENCY DRESSING.  
TAKE THIS TO YOUR FAMILY DOCTOR  
FOR ADDITIONAL CARE.

Another plague attached to the service is the ambulance-chaser who seems miraculously to appear from thin air on the heels of any accident case in which public liability is involved. Great care must be exercised to make certain that no information leaks are present which might involve the hospital as a collaborator in such practices.

The treatment of acute and chronic alcoholics presents a difficult problem, one which the hospital will inevitably face and one that requires forethought in the development of definite policies to meet it. Even more to be dreaded is the psychotic who is literally "dumped" at the entrance. At times the administrator himself may be required to make out commitment papers at the district attorney's office.

The establishment of the new psy-

chiatric inpatient unit at the hospital has added a resident in psychiatry to our emergency staff and has greatly improved the emergency treatment given to patients who have attempted suicide and others with psychiatric symptoms. Cordial relationships with the police department can do much to mitigate the problems presented by both the foregoing types of emergencies.

The problem of indigency can become an acute one. The transfer of eligible patients to the county hospital will offer a partial solution. In most counties, however, eligibility is determined by a complex set of regulations, the stringency with which they are enforced seeming to vary with the number of available beds. For example, an indigent patient, to be eligible, must have been a resident of California for three years and a resident of the county for one year.

The ideal situation will obtain when a reciprocity agreement exists between the county institutions and the voluntary hospitals, and among the various counties so that regardless of residence, indigents can be treated at voluntary hospitals without undue financial burden.

It is contended that every community hospital should provide adequately for the prompt and efficient treatment of emergency patients. While it has been pointed out that there are many problems connected with the conduct of an emergency service, there are even more serious problems encountered when the hospital is not prepared to render this type of care. No amount of explanation will placate a person who presents himself to the hospital in an emergency if immediate treatment is not instituted for the relief of his condition. The potential effect of the department on the quality of public relations enjoyed by the hospital warrants the expenditure of every effort to ensure that it is an excellent one.

We have pointed out some of the requirements for the successful operation of an emergency service as conceived and set up at our hospital. A review of the comments made by patients over a long period of time leads one to believe that the basis of operations is sound. Continued success will be assured only through a constant effort to maintain and raise the standards and the continuation of an earnest desire to be of service to the community.

# The Degree Doesn't Make the Nurse

**"It is not necessary to destroy the present system or to make the registered nurse a displaced person in order to improve nursing education."**

**—J. Milo Anderson**

IN SEPTEMBER 1948, "Nursing for the Future," a report prepared for the National Nursing Council by Esther Lucile Brown, Ph.D., was published by the Russell Sage Foundation. Dr. Brown, in her report, proposes that control of the education of the professional nurse be taken from hospitals and placed in the colleges and universities of the country.

She writes, "Hospitals predominantly are operated on the authoritarian principle rather than that of a cooperative team relationship. The nursing service is caught between the authority exercised by the medical administration, on the one hand, and the hospital administration on the other. Many thoughtful persons are beginning to wonder why young women in any large numbers want to enter nursing as practiced, or schools of nursing as operated today."

## NURSING EDUCATION DEPLORED

In September 1949, Genevieve and Roy Bixler wrote in *The Modern Hospital*, "The modern hospital must relinquish the control of nursing education to institutions whose primary purpose is education." Recent issues of many of the official journals of nursing and medical organizations have published articles or editorials deploring the state of nursing education as it now exists and demanding that control be transferred to institutions of higher education. A national magazine for women published an article devoted to criticism of the schools of nursing of today.

State nurses' associations and national nursing organizations are establishing committees and councils to study nursing education for the future and to "implement the Brown Report." They all agree that the three-year hospital schools of nursing must be eliminated. Some steps have already been taken to eliminate them. Six national nursing organizations have joined together to form a national accreditation service. This accreditation service sent to every school of nursing a questionnaire and on the basis of this questionnaire alone has

**J. MILO ANDERSON**  
Superintendent  
Methodist Hospital  
Gary, Ind.

established the ratings of all the schools that answered.

The accrediting service has somehow decided that 25 per cent of the schools would be permitted in group I, the highest rating, and that 50 per cent could be in group II. The remaining 25 per cent cannot be accredited, and their names will not be published. When they received notice of their ratings, the schools were informed that if they did not wish their names included in the published list, they would be omitted along with the nonaccredited schools. It was also stated in this notification that, if they wished, schools could ask to have their rating reviewed—in two years!

The *American Journal of Nursing* has already published the names of the schools that are in Group I. Four of the 27 previously accredited schools in Indiana are in the top 25 per cent. By coincidence, all four are collegiate schools of nursing.

It is time that the hospitals which are conducting these "inadequate" schools of nursing analyze the criticisms that are being made of them and, if it is not too late, determine whether or not they are willing to relinquish the control of the education of nurses to someone else. If this analysis is not made soon, the snowball of enthusiasm which is now developing may destroy the existing system of nursing education without creating something better to take its place.

One of the most frequently encountered complaints against today's schools is that the curriculum does not meet the needs of modern nursing. It is too limited in scope. The nurse of today requires a more thorough understanding of such subjects as sociology and psychology and she should, in addition, be given courses

in philosophy, anthropology and others if she is to understand the "whole" patient. It is said by many that nurses today are performing tasks which were, until recently, done by physicians and, therefore, more academic and less clinical experience should be included in the curriculum.

The statement is frequently made that instructors found in hospital schools of nursing are not qualified either by education or experience to be educators—that these instructors seldom meet the requirements demanded of college or university faculty members.

## CHIEFLY CONCERNED WITH SERVICE

Another common criticism is that because hospitals are chiefly concerned with nursing service, students are required to spend much more time than is necessary for educational purposes giving service to the hospital. It has been said frequently that the chief reason most hospitals are conducting training schools is to provide themselves with inexpensive nursing personnel. It is righteously proclaimed that the use of the student's time on the wards must be exclusively for purposes of education.

It is claimed that the title "registered nurse" does not carry the prestige that accompanies a college degree. Most young women want a college education and because of this the more academically desirable students are not attracted to the nursing profession.

These are the weaknesses oftenest mentioned by those who would eliminate hospital schools of nursing. They should be examined carefully, first to determine whether or not they are justified and, second, to see if the transfer of responsibility for nursing education to colleges or universities would correct them.

There is some justification for the criticism of the curriculum. It is more

than 10 years since the recommended curriculum was last revised by the National League of Nursing Education. However, the curriculum can be revised and the new courses of study can be taught in the hospital school. Careful consideration should be given to which of the liberal arts and social sciences should be added to the basic course of study for nurses and which should be offered to those students preparing themselves for instructional and supervisory positions.

The statement that the services formerly rendered by doctors now being the responsibility of nurses require more classroom and less clinical teaching is not entirely sound. Most of them are technicians and require more, rather than less, experience on the wards.

The recruitment of qualified instructors for schools of nursing is a major problem. There is truth in the statement that hospital schools employ inadequately trained teachers who would not be accepted on college faculties. This, however, is not the result of negligence on the part of hospital schools.

#### REQUIRE BETTER BACKGROUND

As in every other field of education, the instructors require a greater educational background than those they teach, and enough nurse educators are not now being produced. This situation would be just as acute if colleges and universities were responsible for all nurse education. Hospital schools are attempting in every way to find the kind of instructors they need.

The problem of the abuse of the term "clinical experience" is a basic one. It is nearly impossible to establish a clear-cut distinction between that part of a student's time which is exclusively clinical experience and that which is hospital service. It is also difficult to establish how much clinical experience is required to prepare a nurse for unsupervised care of the sick.

How many diabetic cases must a student observe before she can recognize the symptoms of diabetic coma? How many postoperative or postpartum patients must a student observe before she can properly treat shock or hemorrhage? To give a nurse judgment takes a long time and the observation of many cases. Up to the present time hospitals have been educating nurses not only to give institutional bedside care under

supervision, but also for other fields where they are required to give medical care which is largely unsupervised—such fields as home nursing and public health nursing. The registered nurse is licensed by the state to give nursing care in whatever situation it is needed.

That there are abuses made by some so-called accredited schools cannot be denied, but this does not prove that the system is unworkable. State accrediting agencies now have the authority to correct these abuses if they choose to use it. There is some question that the transfer of control of nursing education would in itself prevent the use of a student's time for service rather than experience. As has been mentioned, the line of distinction is not clear and the hospitals being used for teaching will have the same budget problems they have today.

It is probably true that a college degree is accorded more prestige today than the title "registered nurse." This is in large part owing to the efforts of the nurse educators themselves. If they continue to depreciate the R.N. in comparison with the B.S. this will always be true. The registered nurse was once looked upon with more respect than the college graduate. This could be true again. But at their conventions, in their publications, and in their teaching directors of schools of nursing and instructors have learned to belittle the prestige of the R.N. It is questionable that a college degree is required to prepare a good bedside nurse.

Assuming that the decision should be made to transfer all the teaching of nurses to colleges and universities within the next decade, it is doubtful that they would be able to accept the task. According to the United States Office of Education, in the fall of 1947 there were 678,977 women enrolled in the colleges of the country. It is conservatively stated that 45,000 nurses should be graduated annually, which would mean an increase in enrollment in our colleges of at least 135,000 students. Since it has taken more than a century to build colleges to their present capacity, there is a question whether they could expand another 20 per cent to accept this responsibility. The cost of housing alone would be staggering.

Nursing education can be improved. It can be improved in hospital schools of nursing. It is not necessary or

practical to destroy the present system or to make the registered nurse as we know her today a displaced person in order to improve it.

First, revise the curriculum. Eliminate the courses which are not required and shorten those which are overemphasized. A nurse can learn all she needs to know of the history of nursing in two hours of lectures. Add new courses of instruction and strengthen others as today's nursing requires, but give clinical experience as respectable a place on the curriculum as medical schools do.

Second, the most urgent need in nursing education is for more and better trained instructors and supervisors. Enlarge and strengthen schools for graduate nurses. This must be done in colleges and universities just as it is for educators in all other fields. Then make graduate education more widely available through scholarships. Hospitals operating schools of nursing might well establish these scholarships. When qualified instructors and supervisors are available, state accrediting agencies can require hospital schools to employ them.

Third, those who would transfer all nursing education out of hospitals reluctantly concede that some time must be devoted to clinical experience, but they look at it with suspicion. However, bedside nursing is a skill which must be learned and taught largely by the apprentice method. Supervised clinical experience is an important part of the nursing curriculum and must be given proper emphasis. This can and is being done well in hospital schools.

#### GREAT MAJORITY IN HOSPITALS

The great majority of employed nurses are either on hospital pay rolls or are working in hospitals on private duty. Hospitals must reserve the right to have some voice in the preparation they receive. The present system of nursing education is the best available at this time. The activities of the national nursing organizations are already undermining the confidence of the public in our schools of nursing, even though these groups have nothing ready to replace them.

If it is necessary to change nursing education radically and if it becomes possible to do so educationally and financially, hospitals, the largest employers of nurses, must accept their responsibility and take the leading rôle in making these changes.



FROM THIS . . .

IT WAS at least the ninth or tenth time the disposal truck had pulled into the rear drive at the Northwest Texas Hospital, Amarillo, Tex. There was an expression close to awe on the face of the truck driver as he again watched hospital clerical and janitorial staff members tote out carton after carton and bundle after bundle of papers. It wasn't possible—even in Texas where the huge is merely average—that there could be such an accumulation. But the truck driver who was also night engineer at the hospital hadn't ever been around the hospital records.

Had he been more experienced in the way medical case histories and other documentary records pile up he would have been able to take the whole procedure of disgorging hundreds of thousands of files, folders and individual sheets from two fairly large rooms at Northwest Texas as a matter of course.

The real surprise came when he was given a look at the picture which presented itself to hospital authorities as the last of the cartons and bundles was hoisted onto the truck. Over in one little corner of the other room in the hospital there now stood a single, compact cabinet containing a few small drawers—and an exact copy of every single one of the medical case histories.

Not only was there, in that little cabinet, a complete transcription of all the papers that had been dumped onto the truck on trip after trip; it was all there on tiny rolls of film, properly

authenticated and indexed for quick, easy reference.

The policy of saving medical case histories, whatever its advantages from a professional standpoint, can have at least one serious drawback, *i.e.* it certainly eats into valuable hospital space. Even on the basis of the relative current condition of its files, the management of the Northwest Texas Hospital found that to be so.

This institution, which admitted its first patient in 1924, has since that date accumulated thousands upon thousands of medical records. Until recently, these papers filled two rooms, with no end in sight; yet they could not be destroyed.

. . . TO THIS



## IT'S ALL DONE WITH CAMERAS

LEWIS T. BOLGER  
Sparta, N.J.

These records are important to the hospital, the patients, the physicians and also to insurance companies and induction boards. They are also valuable to the medical researcher, the embryo nurse and the internist physician, for these records are detailed stories of the patients' stay in the hospital: the symptoms, the medication given and corrective steps taken, the patients' response to treatment. Most hospitals still retain in their files all case histories back to the hospital's inception, although this practice is varied according to the various state statutes of limitations.

In spite of their value, however, it is generally considered that the space utilized in storage of these records over long periods exceeds the value of the record themselves. The board of managers of Northwest Texas Hospital, faced with a real dilemma, at this point, authorized F. F. Beringer,

hospital superintendent, to have the material microfilmed.

The organization which supplied the equipment took over the complete job of transferring bulky original records and documents to microfilm. The only thing the hospital's administrative staff had to do was to show the technicians where the records were and then take over the indexed, authenticated film

record after it had been completely processed.

The hospital staff found that reference to hospital case histories on filmed records is many times faster than it was to the original records. In most instances locating and flashing a given record on the film reader takes less than a minute.

Today, the records whose bulk for-

merly crowded two big rooms are stored on microfilm in one small corner of the hospital library.

Some indication of the space saved is given by these figures: 160 standard letter-sized filing cabinets set in four rows, 40 cabinets to a row, require a room 60 feet by 20, or 1200 square feet, for housing; a film cabinet, on the other hand, uses less than 10 square feet of floor space. Approximately 3000 letter-sized documents can be placed on a roll of film no larger than a hand. A stack of records as high as the Empire State Building, over 2½ million letter-sized records, can be reduced to a size comparable to that of a standard filing cabinet. Moreover, this film, on which these papers are now recorded, if properly processed and stored is more durable than are records made on the finest grade paper.

To return to the microfilm setup at Northwest Texas Hospital, when a record is needed for reference, a physician can consult the record library index and select the film needed. Incidentally, these microfilmed records cannot be inadvertently misfiled; they are at a certain spot on that film, proof against altering and tampering. The film is then placed in a "reader," an electrical projection device which throws the record on a screen. The screen makes this record appear in its full size for the convenience of the person reading the projection. Regardless of how the records have been photographed (upright or otherwise) a twist of the knob will bring the image instantly into a readable position.

If a copy of any microfilmed record is desired—perhaps copies of records are to be sent to another hospital, physician or court—the reader can be employed as an enlarger. With the use of the sensitized photographic paper and a simple developing operation, a black-on-white copy can be made easily and quickly. By use of this method, the possibility of errors in transcription is obviated; moreover the cost of producing photographic copies in this way represents a very small fraction of what manual copying would cost.

With its old clinical records now on film, the Northwest Texas Hospital intends to do the same, at intervals, with its newer records, as these accumulate from day to day. Superintendent Beringer expresses himself as well pleased; the removal of paper provides that much more space to help relieve an overcrowded condition.

## What Hospitals Can Do About LEGISLATION

I SHALL confine my remarks to legislation on the state level. As each year passes the number of bills filed affecting hospitals directly and indirectly increases. In some of our larger states it has become almost a full-time job to follow legislative matters.

The promotion of good legislation or the defeat of bad legislation cannot be effectively accomplished without the coordinated effort of at least a majority of the hospitals in a state.

It is highly desirable to have a state hospital association with an able legislative agent. At the beginning of each legislative year an analysis and study of the proposed legislation should be made by a small group of hospital leaders. The Massachusetts Hospital Association has its council on governmental affairs make the study and report its recommendations to the trustees. The trustees decide on the position to be taken by the association, and action decided upon is carried out by the executive secretary and the legislative agent.

The nature of each bill and its effect on hospitals largely determine the extent of the support or opposition, as the case may be. Oftentimes punitive legislation can be defeated in committee. If it is desirable to press for the defeat of a measure by a certain legislative committee, a study of the committee should be made first. Hospitals located in the committee member districts should be contacted and asked to make their views known.

Legislators do respond to the wishes of their constituents. Public demand for or against legislation carries the greatest weight with politicians. Legislators often count the number of letters received for and against a certain bill.

This brings up the matter of public

relations. The general background for hospital public relations should stem from the American Hospital Association. This should be supplemented on the state level for local matters. The support of the press is of paramount importance on any major legislative bill. I believe that the newly organized statewide women's auxiliaries can and will play an important rôle in influencing public opinion regarding hospital legislative affairs.

Legislators are asked to vote on thousands of measures during the course of a year. They cannot be expected to know the exact contents of each bill. It is necessary to inform the representatives and senators of the facts in each case. These facts must be presented at the proper time. Information received too early in a session may be forgotten at the time a decision must be made. Reminders are often necessary when prolonged delays occur.

The Massachusetts Hospital Association's legislative program was quite successful this year. Legislation to tax hospitals and Blue Cross was defeated. A bill which would have strangled Blue Cross with restrictions was also defeated. The association sponsored a measure to require the state and municipalities to reimburse hospitals their actual costs for hospitalization of the aged, dependent children, and welfare cases. This was approved but a ceiling of \$10 per diem was imposed. It is estimated that this will net the hospitals an additional \$4,500,000 per year.

Our accomplishments could not have been possible without the wholehearted support which was received from many of the hospitals throughout the state.—THEODORE W. FABISAK, executive secretary, Massachusetts Hospital Association, Boston.

## THE DOCTOR PRESCRIBES BEAUTY

SHOULD your doctor prescribe a shampoo, finger wave and manicure when you consult him for nerves, lack of energy or similar ailments, what would you think? You would probably decide that he was a little on the psychotic side, or that perhaps he had acquired a financial interest in some beauty establishment. However, hundreds of such prescriptions are actually made out every month by ward physicians of the Napa State Hospital at Imola, Calif.

In some ways Dr. Theo K. Miller, superintendent of the hospital, might well be called a visionary. So he is, but his dreams for the happiness and well being of the mental patients under his care are constantly materializing, and one of his advanced ideas is the hospital beauty parlor, the "Vanity Shop," which held its formal opening on May 6, 1947. By the end of the fiscal year on June 30, 1949, we had recorded 21,540 shampoos, 21,490 finger waves, pin curls or braids, 2121 manicures, 9489 hair cuts, 681 scalp treatments, and 127 permanent waves. The last feature was included in the shop program in January 1949.

### OBSTACLES IN THE WAY

It was not easy to develop Dr. Miller's idea into the efficient and smooth running organization that the shop has become. Like pioneers in any field, Mrs. Mabel Knudson, the cosmetician manager of the "Vanity Shop" had many obstacles to hurdle, psychological as well as practical. There were prejudices to be overcome; the innovation of such a luxury as a beauty parlor in a mental hospital was bound to bring forth a certain amount of incredulity and even ridicule among hidebound conservatives.

Until the unbelievers were converted it was difficult to operate because complete cooperation between hospital and shop was necessary for the successful functioning of this venture. Gradually misunderstandings were eradicated; we have achieved success, largely owing to the interest and support of the ward attendants, most of whom were sympathetic and helpful from the start.

### *"Vanity Shop" is an important aid in the treatment of mental illness*

**MRS. GRACE F. McCONNELL**  
Psychiatric Aide  
Napa State Hospital  
Imola, Calif.

When Dr. Miller selected Mrs. Knudson to manage this enterprise he said, "Run this unit as you would your own shop if you were operating one on the outside." That is a large order in a mental institution, but she has carried out these instructions successfully. As in any beauty shop, there are no locked doors, there are no restraint devices whatever, although patients from all wards are treated, even the acutely disturbed ones.

The women are permitted and often, in the case of timid ones, encouraged to smoke while undergoing treatments. So far we have had one runaway, and once we were obliged to call for aid in restraining a suddenly disturbed patient. That is not a bad record, all factors considered. At the first sign of unusual agitation we separate the disturbed customer from her group and return her to the ward as soon as possible.

The "Vanity Shop" is situated in a central part of the large hospital grounds in one of the army surplus buildings purchased by the state. It has a warm, cheerful atmosphere and is generously furnished with the most up-to-date and modernistic beauty parlor equipment. There are six shampoo basins, 12 vanity dressers, 12 dryers, 30 chromium chairs, as well as all the usual accessories that go with an attractive salon.

This novel beauty parlor is strictly an activity for the patients by the patients. With the exception of Mrs. Knudson and me (the attendant assigned to assist her) the work is carried on entirely by patients who are trained under the manager's skilled

guidance. Approximately 2000 individuals have been treated in the shop to date. This number means that many patients have made regular and frequent visits during this time. During the last fiscal year 42 women were employed as operators in the shop. Of this group 11 were discharged from the hospital as recovered or so improved that they could return to their families. Others were rejected as workers and some were transferred to different types of institution work.

### SELECTED BY DOCTORS

The average staff made up of patients consists of 10 operators and two shop workers. One of the latter, a most efficient person, has entire charge of disbursing supplies to the operators while the other assists her and attends to the picking up incidental to the work. The beauty operators are selected by the doctors and are assigned to the work as part of the hospital's occupational therapy program. They are consulted as to their preference for the type of occupation they would like to follow. If they seem interested in beauty culture they are sent to Mrs. Knudson for observation. If they are adapted to the work and happy in it they are then fully trained. The contentment of a patient in her work is a primary aim of occupational therapy.

When a patient is assigned to her, Mrs. Knudson immediately acquaints herself with the case history so that she may thoroughly understand the type of illness and personal problems of her charge. With this intimate knowledge she is able to cope intelligently with almost any special vagary of her girls. Although she has had no previous experience with psychotic people she intuitively possesses the

key to success in this field. That key is composed of affectionate understanding along with the quiet firmness necessary to maintain orderly routine. Even under trying circumstances one never sees her lose her equanimity. All the regular staff members are happy in their work, and most of her pupils have become expert operators.

Not all are adapted to this occupation, and it is often necessary to reject some because they are still too nervous and ill themselves to contend with the more difficult and troublesome patients who come to the shop. A degree of emotional soundness and reliability are necessary qualifications for our workers. Even though closely supervised they have responsibilities far above those of the average patient. In such an employment they are of necessity permitted the use of scissors, clippers and other equipment which could be used disastrously by entirely irresponsible persons!

The majority become competent and interested workers and give daily evidence of sympathy and understanding of the clientele, especially those who are obviously and seriously ill. A visitor once remarked that she was deeply touched and impressed by the relationship existing between our customers and the operators.

#### **PATIENTS ARE GRATEFUL**

The former respond with grateful appreciation to the painstaking care and personal attention that reestablishes them as individuals rather than mere members of a group. Many of the customers have favorite operators and they are free to choose who will beautify them. Of course there are occasional antipathies, too, but these little flare-ups are usually handled tactfully by the operators themselves.

This training system of the "Vanity Shop" not only helps the patients adapt themselves to organized work here at Imola, but serves as a preparatory school for future careers. Many have expressed a desire to go on with beauty culture when they are released from the hospital. The knowledge and experience thus gleaned can prove invaluable in rehabilitation at a later date. Any one of our recovered operators wishing to follow this career would be eligible to take advantage of the state rehabilitation plan. At no cost to herself she would be sent to a school of cosmetology to qualify for employment as a licensed operator.

It is to be hoped that some of Mrs. Knudson's "graduates" will take advantage of this opportunity.

The shop is operated on a prescription basis, that is, prescriptions for individual treatments are made out on the various wards and are approved and signed by the ward doctors. The forms are sent in to the beauty shop each Monday. Appointments are made in groups and the wards are accordingly notified by telephone.

#### **MORE THAN 200 PRESCRIPTIONS**

The number of weekly prescriptions averages well over 200; these must be included in a five-day working week. As there are 28 wards and too few days many problems arise in making these arrangements. For instance, booking on or immediately before a bath day must be avoided, otherwise the cherished coiffures would be ruined too soon. We also try to avoid taking a group if special recreation has been planned for it. It sometimes seems an impossible task yet we usually manage to maintain amiable relations with a little mutual give and take!

The average number of patients treated in the shop per day is 42. This means that four groups of 10 or 11 each are handled daily. The first group is taken at 8 a.m. and the second follows about an hour later. Therefore the first contingent must have hair cuts (if necessary), shampoos, and be well under way with hair sets by the time the others arrive.

Since the number of operators and facilities is limited it is only by clock-like precision that the program is maintained. Patients must be returned to their wards in time for meals, so promptness is imperative. Over two hundred treatments are averaged during weeks in which no holidays fall. Our peak month was December 1947. We operated with a full quota of 12 girls who managed to turn out more than one thousand hair-dos.

The patient clientele is for the most part escorted to and from the wards. Women with privilege cards, however, are granted freedom of the grounds, and they come and go as one would visit an ordinary beauty parlor. Individual tags are prepared for the day's treatments bearing the name of the patient, her ward, type of treatment prescribed, and whether or not she possesses a privilege card.

This information tells the operator at a glance what work is to be done

and which persons are to be taken first. It also facilitates controlling the strict count which must be kept when patients are taken from the wards. Should a patient escape unnoticed, the attendant in charge would be subject to severe disciplinary measures.

Many of our women visitors are well and are on their way out. They enjoy the luxuries of beauty treatments during their stay and the sense of well-being that an attractive coiffure brings to every woman. They respond to the informal atmosphere of the shop and chat, read and smoke while here. We learn their joys, sorrows and hopes, and often hear little bits of gossip such as most women impart to their own beauty operators when literally "letting down their hair." We are among the first to hear the joyful news of a home-going conference and go all out to beautify them for this day of days.

#### **SOOTHE FEARFUL PATIENTS**

Others are not so far advanced on their way to health, and there are many pathetic incidents in our daily routine. Some come in fear and trembling with the apprehension that novelty or change brings to certain types of mental patients. These are reassured and encouraged. When they are truly agitated they are soothed and told to watch their companions enjoying the shop services. Often they are calmed to the point of submitting to treatments on their first visit.

One of the most apprehensive and reluctant visitors is now an eager patron. She cannot wait for her own regular appointment, which on her size ward falls about every third week; she actually coaxes to be sent as a substitute when someone else is unable to come. One of the greatest thrills in this work is to see a patient responding to hospital treatments, such as electric shock therapy, and making real progress toward mental health. Sometimes in a few weeks or months miraculous improvements are evident. These happy incidents serve to compensate for the more pitiful ones. Of course, many remain in a prolonged state of illness but even chronic cases have learned to look forward to their beauty appointments and are pleased and happy with becoming new hair-dos.

The improved appearance of the women is frequently commented upon, especially by relatives of long-time patients. They are cheered and encour-

aged at being greeted by a well groomed wife, sister, mother or daughter, looking as she did in happier years, and they often come to the shop to express appreciation. One mother came in to inquire how much she owed us, as she did not understand that the treatments were a part of the hospital service. She thought that there must be a charge for which she was more than willing to pay.

#### HAS ACCOMPLISHED PURPOSE

When Dr. Miller instituted the "Vanity Shop," the practical idea of improving the appearance of his women patients was secondary to his psychological perception that this feminine industry would be of great therapeutic value in increasing morale and promoting the personal pride that is the birthright of every woman. That he has accomplished this purpose is manifested by the remarks made from time to time by customers in various phases of mental illness, and which we shall quote as follows:

M.K., an elderly alcoholic, said, "You are doing a great job fixing up us old ladies. It makes us feel better all over."

M.W., a wiry little 60 year old who never misses a hospital dance, remarked while preening herself, "If only my little grandchild could see me today. What would she think of Grandma now?"

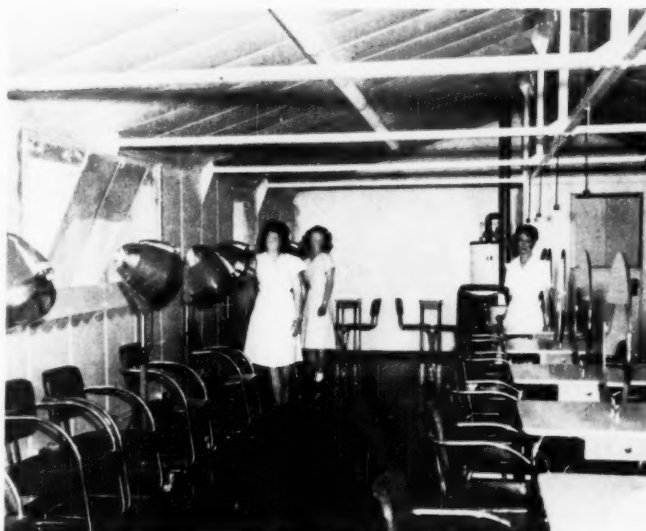
K.W., a former school teacher and a regular patron, made the appreciative remark, "It is lovely to be able to come down here and have one's hair set so nicely. It is such a help in every way."

E.B., another former teacher, said, "It is a pleasure to come to a place like this where we get so much personal attention. We all love service, don't we?"

E.G., a stout, jolly woman of the chronic mental type, was happily admiring her new hair set in the mirror. When asked how she liked her wave she exclaimed in unrestrained enthusiasm, "Oh my God, it's magnificent!"

N.I. told us, "My husband was delighted with my appearance when he visited me. He was surprised and pleased at the idea of a beauty parlor in the hospital. To know that I am being so well cared for makes him happier at leaving me here."

C.B., a woman who was once a buyer for a well known San Francisco dress shop, said on her first visit, "It is swell to come over here for our beauty treat-



Mrs. Knudson, manager of the shop (right) and two operators.

ments. You treat us as if we were real customers in any outside shop."

T.B., who was under treatment in an acute disturbed ward, stated, "I tell you these new fangled hair styles make me feel real sporty. I feel like stepping out some place!"

H.M., from the same acute disturbed ward, reacted with this remark, "It sure feels good to get into a normal environment again. I feel there's hope for this old gal yet!"

J.S. cried as she was having her hair combed out. When questioned as to what was troubling her she said, "If only my folks could see how pretty I look today."

M.S. an elderly woman who has been in the hospital for years said, "I've never been in a beauty shop in all my life. Just wait till I tell the folks!"

So much for the complimentary remarks, but we hear unflattering comments as well. One fussy old lady was included in a group against her will and she flatly refused to have any part of our services. I tried to point out to her the advantages of having her hair shampooed in the shop rather than on the ward. She listened to my sales talk and then snapped, "Well, if you think it is so blank blank wonderful you can sit down and have your own hair washed. It looks as if it needs it more than mine does, too!"

In conclusion, let me quote the following conversation that I held with a patient on the way over to the shop.

CATHERINE: "Do you think the beauty shop pays?"

ATTENDANT: "Do you mean is it successful?"

CATHERINE: "Yes, I was wondering if it is worth all the trouble they take with us over there."

ATTENDANT: "Well, Catherine, you've been coming regularly for months. What do you think about the treatments?"

CATHERINE: "I think they are just wonderful for our morale and I know the girls look better. I love to come over."

ATTENDANT: "You have answered your own question. Just to have a few of you feel like that makes the beauty shop pay, as you say."

The foregoing remarks were made in all sincerity. Some are pathetic and some are amusing. However, we quote them in respectful tribute to our grateful patients and in no spirit of levity. There is humor and even happiness of a sort in this little world of ours at Imola, but it is shadowed by the pathos that is so intimately a part of mental illness.

We who have watched the development of the "Vanity Shop" feel that it has justified its existence from a therapeutic as well as a humane standpoint. It has contributed a share toward helping many on their way back to reality, and is a means of comfort and happiness to those for whom there may be no return.

# How to put the control in INVENTORY CONTROL

## Purchasing

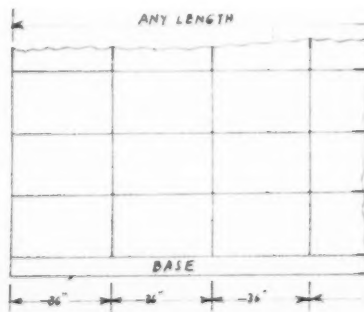
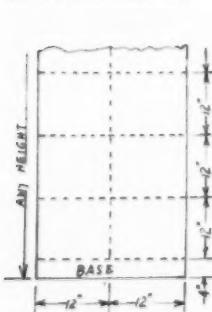
THE purchasing function does not depend entirely upon the inventory control system; usually it depends upon inventory control only as far as inventoried items are concerned. A control system gives the purchasing department considerable information, enabling it to buy intelligently. In fact, it eliminates most of the guesswork in buying. For instance, it tells what, when and how much to buy, where it was previously purchased, how much was paid for it and how long it took to get it.

Since an inventory system shows everything in stock and how much is being used it shows up the different varieties of each item carried. An effort can then be made to eliminate some of these varieties and standardize on fewer items or use a different item that will still accomplish the desired results.

Sometimes a department will turn in a purchase requisition for an item that is but slightly different from one already in stock. If the purchasing department is on its toes it will know this and the requisitioning department when so informed will often be able to use the item already in stock, thereby making a new purchase unnecessary.

This is the second and concluding section of an article on inventory control. The first appeared in the November issue.

## DESIGN FOR SHELVING



When goods are scarce and promised delivery dates are unreliable, it will naturally be necessary to carry a larger inventory in reserve than when goods are plentiful and delivery dates more certain. But this does not mean that the purchasing department must run wild and buy everything in sight and in such excessive quantities that the hospital cannot store or pay for them. A good look at the inventory records will ascertain how fast an item is being consumed and reserve buying can be governed accordingly.

When goods become scarce and will take, say, six months to obtain, why, will someone please tell me, is it necessary to carry a supply that will last for years?

## Storeroom Arrangement

Considerable thought must be given to planning and arranging a storeroom. The storeroom must contain ample shelving, bulk storage space, stowage bins or shelves, a very large work table or counter and office equipment. These must all be arranged so as to utilize every square inch of space to the best advantage. The shelves must be designed to hold the greatest amount of goods without crowding and still economize on space. A good shelf section is illustrated.

The sections are made as long as the room dimensions allow and are made just high enough so that the

employees can conveniently reach the top. They should sit on a base at least 4 inches high. Twelve inches between shelves, 36 inches between supports and 12 inches deep are good measurements. These sections are made double, that is, back to back. Never allow a blank wall in the shelving area to remain blank; place a single shelf section against it. These specifications are for medical and surgical stores; food stores require an entirely different setup. In placing shelf sections allowance must be made for a main aisle of at least 5 feet in width and sub-aisles between sections of at least 30 inches.

The knowledge of a good experienced storekeeper is indispensable in arranging a storeroom; the management would do well to rely upon his knowledge.

If the storeroom is not large enough to accommodate all the supplies and equipment on the inventory without crowding, then additional space capable of being locked must be furnished. Always bear in mind that the storeroom is not a repository or storehouse for all the hospital's cast off odds and ends of junk but is used strictly for housing inventoried supplies and equipment and nothing else. It may, however, if space permits, be used for the temporary storage of new items that are not on the inventory.

Storeroom arrangement may seem to have no bearing on inventory control but actually proper arrangement and storage are such integral parts of inventory control that they cannot be ignored. The discussions on classification and identification of stores will bear this out.

## Classification of Stores

Every item carried on the inventory—irrespective of what it is, how big or how little or how insignificant it may seem—must be carefully analyzed, physically, that is, to determine its classification and should be carried on the inventory in that class. When an item's classification has been deter-

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[illegible]

signed for by the addressee or his representative.

A receiving slip (see sample) should be made out for everything received that has been purchased by the hospital. This is a simple form made out by the storekeeper. It is made in triplicate, the original for the purchasing department, the duplicate for the inventory records clerk (if any), and the triplicate is retained by the store-room or receiving department.

The receiving slip contains such information as the shipper or vendor, purchase order number, how shipped, date received, received by, checked by, the disposition of the item, the vendor's count (as it appears on the packing list, if any), the actual count received, and the full name and description of the article. The slip is approved by the head storekeeper. The original is then clipped to the freight bill and the packing list and forwarded to the purchasing department.

The storeroom or receiving department copy of the purchase order, along with the receiving slip copy, is retained by the storeroom or receiving department. Any discrepancies found in goods received are noted on this department copy of the purchase order, and the receiving slip, of course, and not on a separate piece of paper which will probably be lost. This method provides a permanent record of what has or what has not been received and will help considerably in settling any

future disagreements. It is of the utmost importance that these records be accurate.

## Storing

Storing is another situation that sometimes presents quite a problem. It is also a problem that cannot be treated lightly because it plays such a major part in helping to control the inventory. The problem consists, substantially, of three basic factors: (1) storeroom organization; (2) classification and identification of stores; (3) providing sufficient space properly to store and protect everything.

A well organized storeroom is headed by an experienced general storekeeper who supervises its performance. He must have capable assistants and cooperative support from his department head and the management to make the storeroom function properly. If he does not have these things it is useless for him to try to supervise anything.

There are many hospital executives who contend the storeroom copy of the purchase order should not show quantities ordered; there are many who contend it should. The people who are opposed to showing quantities also keep the storeroom personnel in the dark about other matters, plainly showing their distrust for their employees despite the fact that they may be good dependable workers. These executives get just exactly what they ask for and no more. I maintain that when an

executive has good employees and lets them know he trusts them he will never have to worry about getting inaccurate receiving records—or anything else for that matter. His department will function perfectly.

When the storeroom copy of the purchase order shows the quantities ordered the storekeeper will know in advance what to expect and will be prepared for receiving and storing it. This tends to eliminate the stupid waste of time and manpower resulting from continuously moving stock about the storeroom to make room for new items or an excessive quantity of something or other.

"A place for everything and everything in its place" is an old, old maxim that should be painted on a board and placed conspicuously in the storeroom. When stock has been received and checked it must be stored. It cannot be dumped in confusion just anywhere and allowed to look after itself; it must be placed in its proper position in its proper classification section. It must be labeled, if necessary, and stock numbered so that there is no doubt as to its identity. Everything must be stored so that it can easily and quickly be found. Stock must also be stored with an eye to economy of space, accessibility and a minimum of handling. To accomplish this, a well defined method of storage must be worked out and everything must be stored accordingly and in no other way.

New stock is always stored so that the old will be used first; there should be few, if any, exceptions to this rule. The surest way to accomplish this is by placing the new back of the old which forces the old to be used first. This rule must be rigidly enforced, for otherwise the hospital could easily lose money through physical depreciation.

Stock is never stored directly on the floor but on wood platforms at least 2 inches high. These may be made any size and shape to fit the storeroom needs and are easily made from any odds and ends of wood that are handy.

The attractive designs so dear to the heart of retail stores in arranging their stock are unnecessary in a storeroom; simply "squaring away" stock in a neat and uniform manner is enough.

Quite often a hospital will have some supplies or equipment that is not being used, has not been for a long time, and probably never will be. Instead of allowing these things to take up needed space for years, why

not dispose of them? It is often possible to realize at least a part of their original cost, which is far better than allowing them to lie around gathering dust, getting in the way and being useless.

### Issuing Stores

The hospital's stores should never be given promiscuously to just anyone who demands them. If the inventory is to be kept accurately, some method of issuing must be used that will account for every item issued. This method is usually some form of stores requisition similar to the one illustrated on page 68.

When a department requisition supplies the stores requisition is signed by the department head or his assistant and the name of the department is filled in. When a ward needs supplies, the head nurse or the nurse in charge indicates the ward and signs the requisition, but before it goes to the storeroom the supervisor for that ward or section approves it. It must be legibly written in blue-black ink or black pencil or typewritten. The person making out the requisition must indicate clearly just what is wanted, the stock number and the quantity needed. The unit price, extension and account number are filled in by the inventory clerk if these columns are used. Sometimes a hospital may prefer to transpose its issues to a summary sheet and extend the cost on it. In this case the stores requisition would not need the cost columns.

When the requisition is filled the issuing storekeeper makes a check mark (✓) if an item is issued, or a zero (0) if an item is not issued. The person receiving the merchandise signs his name at the bottom. The storekeeper then stamps the serial number at the top and the date at the bottom and signs his initials in the lower right hand corner.

Any item that has been issued and is returned to the storeroom must have a credit requisition made out for it, provided it is in usable condition and can be issued again. The storekeeper simply makes out a stores requisition in red ink or pencil which will indicate that the department or ward appearing on it is to be credited with that item. It might be a good idea to write the word "credit" across the requisition. It is then numbered and filed with the other requisitions. The item is then posted to the inventory record card in red as an item received.

Occasionally a department will want to borrow some stock for demonstration purposes and will return it when the demonstration is over. In this case a custody requisition is made out. This is done the same as for an issue of stores except that the word "custody" is written conspicuously on it; it might be well to write this requisition in blue. This requisition is not numbered and filed with the other requisitions

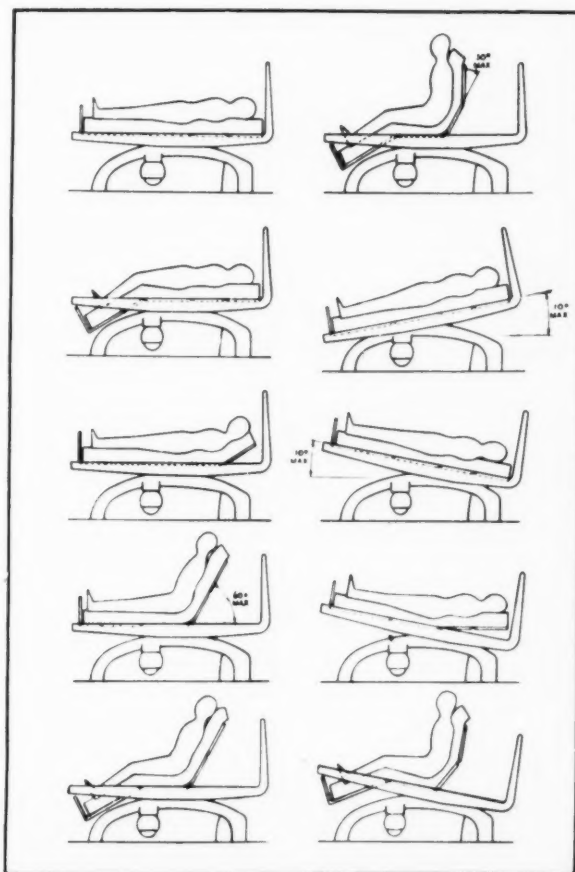
but is filed separately until the items are returned; it is then destroyed. Any requisition that is not correctly made out is not filled but is returned for correction.

This article may make inventory control seem difficult and a lot of work but actually when a good control system is once set in operation the work required to operate it can be taken easily and naturally in one's stride.

### New Bed Is Light, Maneuverable

THE "Magbed," named for the light magnesium alloy of which it is made, has recently been introduced in British hospitals by a manufacturer in Kent, England. Said to weigh approximately half as much as the conventional hospital bed, this innovation is scheduled for extensive testing at a hospital in the East.

Fingertip manipulation by a single nurse is the new bed's outstanding advantage, according to the manufacturer. In addition to adjusting the bed quickly to any of the positions shown in the diagram, the nurse may press a foot lever to lower wheels which make the entire bed easily maneuverable.





HEIDELBERG MILITARY HOSPITAL, MELBOURNE, AUSTRALIA

## Why We Travel

*An Australian architect reports on his travels in the hospital field in the U.S., England, Scotland, Sweden, Switzerland and France*

GEOFFREY L. MOLINE

Stephenson and Turner  
Architects  
Melbourne, Australia

**G**EOGRAPHICALLY, Australia is a long way from the hospital center of the world, and it has a relatively small population. The direct result of this isolation is a great loss to our country in that we lack the easy interchange of ideas and competitive thought that so stimulates activities, especially in the United States of America. Therefore, we are obliged to make constant and sometimes protracted research in other countries if we are to keep abreast of the times.

My journeyings this time are really in continuation of a number of such tours made by Mr. Stephenson and others of the firm over the last 20 years. It was after one such tour that he wrote the series of articles entitled "A Tramp Abroad in the Hospital Field," which was published by *The Modern Hospital*.

This article continues that series.

### STUDY TOURS

Of outstanding value to hospital knowledge throughout the years have been *The Modern Hospital* and, later, the American Hospital Association's publication *Hospitals*. These journals are standard reference periodicals throughout the world. There are many textbooks, too, of great value in the study of this complex problem, but the only really satisfactory method

of acquiring this knowledge is to absorb it firsthand—to inspect the new institutions and discuss the reasons that lie behind their planning and equipping with the "Brains" who were responsible for conceiving them.

These trips are not holidays—far from it. The work is intensive and, owing to the distances that must be covered, there is little time for sight-seeing. The postwar development of airways has brought Australia within a few hours' flying time of America and Europe; consequently, less time is spent in actual travel, which unfortunately eliminates the pleasures of long sea voyages.

There is so much to learn from even brief visits overseas that it is essential to limit the sphere of investigation in any one trip and, I believe, limit the period of study to about four months or less, for constant traveling, seeing new buildings, and talking with new friends is very wearing.

### COLLECTION OF DATA

In order to bring back information of real value it is necessary to have a clear-cut program in mind, because one can easily become confused by the flood of information and published data which fellow architects, administrators and others so freely make available. Each country would do well to

establish research stations, as suggested by Cederstrom of Stockholm, where information might be obtained without constantly worrying the same individuals time and again, because most of such study tours follow much the same route. Such stations would supplement the excellent work already done by the American Hospital Association, the U.S. Public Health Service, the King Edward Hospital Fund for London, and the Centrala Sjukvardsberedningen, Stockholm.

Every country we visit is a storehouse of information; first and foremost comes the United States of America, then the United Kingdom and the northern countries of Europe. There are extreme differences in conditions of hospital service and in functions between the various countries, but from each something useful may be gleaned and molded to our advantage.

### SPECIFIC INVESTIGATIONS

The problems selected for me to investigate on this trip were:

1. Hospital laundries and linen service departments.
2. Maternity and psychiatric departments.

Also I was asked to report on the advances made in general acute hospital design since the firm's last trip. Owing to travel restrictions, this research was confined to the United States, England, Scotland, Sweden and Switzerland, concluding with a brief visit to France.

## OVER-ALL IMPRESSIONS

The main impressions gained during this trip were as follows:

**Planning:** In all countries visited a tremendous amount of thinking and planning was done during the war years for postwar hospital building. In some countries, where supplies of building materials and labor are not severely restricted, modern types of hospitals have been completed since the war.

The standards of construction and equipment have advanced with the development of new materials and methods, but the costs of modern hospital building have advanced far more rapidly. The present period is one of uncertainty and transition during which hospital people are becoming familiar with high costs, and therefore carefully scrutinizing all building expenditure to prevent lowering of standards.

**Administration:** The American administrative system has many advantages over the British Empire's system of divided executive control, where secretary or business manager and medical superintendent or director of nursing are each responsible to the controlling committee.

In medical centers with greater bed capacity than 1000 beds, the administrative control is delegated to senior executives who may be responsible for a building or group of small buildings containing approximately 500 beds.

There is an increasing demand that medical centers for the training of doctors be developed as hospital villages, providing facilities for inpatients, outpatients, private practitioners, and the community housing of hospital workers.

**Linen Service:** The problem of linen service to hospitals and institutions has received considerable attention, and it is now considered that a well-run hospital does not just have a laundry but plans for and operates a complete linen service which starts with the purchase of new materials and finishes when linen is to be condemned.

Various methods have been tried for control of linen: the exchange system, the system of supplying each ward with its own linen, the requisition system, and many variations of these three. It would seem that the majority of well-run hospitals have adopted the requisition system and have limited the counting of individual items, replacing such a check by weighing and

controlling the linen service by spot inventories taken at irregular intervals to prevent hoarding of linen by wards and other departments.

**Maternity Departments:** In the maternity departments there is a growing trend toward the provision of small wards with nurseries close by. In some hospitals the rooming-in plan is advocated as it keeps the baby in closer contact with the mother during her hospital stay. In nurseries the trend is to provide individual cubicles and to restrict nurseries to accommodation for eight bassinets with appropriate ancillary rooms.

In the birth room areas recent developments have demanded a larger proportion of single bed lying-in rooms where normal cases can be delivered, and provision also for larger, better equipped delivery rooms for the more difficult cases and caesarean births, and for teaching purposes.

In some hospitals the linen supply for the maternity department and the sterilizing of linens and dressings are kept entirely separate from the general hospital washing and sterilizing.

**Psychiatric Departments:** In general it can be accepted that the psychiatric department must form part of a general acute hospital, particularly where there is a medical school in the hospital. There has been much discussion as to whether such a department should be planned as part of the general hospital building or whether it should be a distant and a separate building, and the consensus favors the former arrangement.

The aim in every psychiatric department is to give an atmosphere of comfort and well-being, and some departments resemble a hotel or apartment house rather than a hospital. The use of color therapy, careful selection of furniture, and the segregation of quiet, disturbed and noisy cases are noticeable in all well arranged departments.

## SPECIAL POINTS OF INTEREST

**Data:** The work being carried out by the Office of Technical Services of the Hospital Facilities Division, U.S. Public Health Service, has attracted worldwide interest and the various reports and data issued are of inestimable value to all hospital authorities throughout the world.

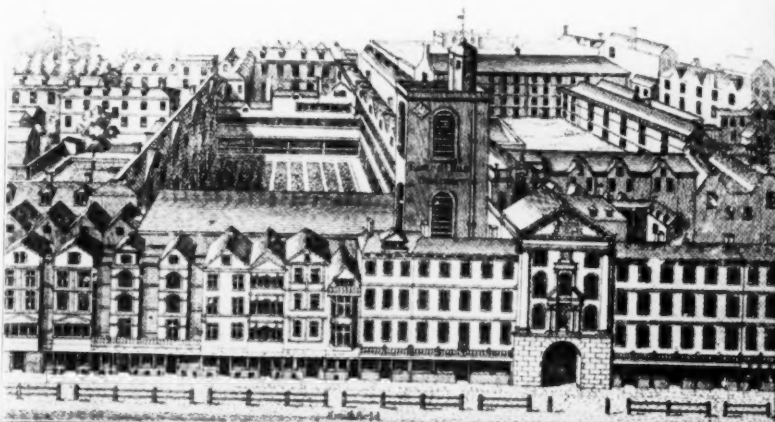
**Planning:** In U.S.A. there is a marked tendency to design hospital buildings on the cross or double cross plan, while in Europe the general planning adopted is of two main types: (a) a long building with ward wings projecting at right angles; or (b) a ward building with a parallel building which houses the outpatient and service departments.

**Materials:** In overseas countries there is a greater variety of materials available for hospital construction than is the case in Australia, particularly in the sphere of hospital equipment. One notices the thought and care taken in both the design and construction of such items as cooking equipment, sterilizers, laboratory fittings, and special treatment equipment. Wherever possible, labor-saving machines and devices are used in order to cut down the ever increasing cost of nursing care and domestic labor.

**Food Service:** The food service in large hospitals is generally by electrically heated and insulated food trolleys to ward pantries or to the patient's bedside, and dishwashing is carried out by small machines in the ward pantries on each ward floor. However, in small hospitals, say up to 150 beds, central food tray service is recommended by many American authorities, and in such cases a central dishwashing area is located near the serving unit.

**Sterilizers:** Owing to scientific advances in recent years, the boiling water sterilizer is being replaced in many American hospitals by small high-pressure sterilizing equipment

ST. BARTHOLOMEW'S HOSPITAL, LONDON





BOOGERSPITAL, BASLE

and, in operating suites, by similar high-pressure sterilizers which also wash the instruments.

**Recovery Rooms:** Recovery rooms on the operating department floor, with easy access from each operating room, are a common feature of many hospitals. Many administrators and doctors favor the holding of post-operative cases in such a room for some hours after the operations are completed in order that intensive nursing by graduate staff, and close observation by surgeon and anesthetist, may be given until the patient has recovered. This principle relieves the heavy nursing of postoperative cases in surgical wards, and has led to an over-all reduction of the nursing staff. Another advantage claimed for this principle is that ward patients are not disturbed by a postoperative case recovering in a normal surgical ward.

**Nursing Units:** Some hospital authorities have suggested that nursing units can be operated on a higher number of beds than has been the practice in the past. A fair average of opinion for the size of nursing units may be stated as follows: (a) up to 20 patients in single rooms; (b) up to 40 patients in four bed rooms; (c) up to 30 patients in mixed arrangement or four, three, two or one bed rooms.

**Pay Beds:** A noticeable difference between American and British Empire hospitals is that the former are designed with a larger proportion of paying beds. Some authorities in America recommend that in a general hospital one-third of the beds should

be provided for private patients, one-third semiprivate, and the remainder public or free beds. In British Empire hospitals it would be unusual to find a general hospital with one-third of its bed capacity in full-pay or part-pay beds.

In some American hospitals, older buildings with large wards have been replanned to form small roomettes to meet the demand of the white collar class for minimum size private rooms at a reasonable cost.

**Nurses' Quarters:** It is a well established principle in overseas hospitals that a proportion of the nursing staff lives away from the hospital. The proportions vary in different countries, but as a general rule it is established that student or trainee nurses should live in a nurses' home in the hospital grounds for the first 18 months or two years of their training. Thereafter students and graduates should be given the right to live out if they so desire. In some cases hospitals have purchased or constructed apartment buildings for the housing of nursing and some lay staff, where tenants pay rental for their accommodation.

**English Hospital Conditions:** From the beginning of World War II, all activities of the United Kingdom were concentrated on winning the war, and there was very little opportunity to plan and construct new hospitals for the civil population. Owing to the present extreme housing shortage it is unlikely that new hospitals will appear in the United Kingdom before 1951. The whole hospital system of the United Kingdom is being re-

organized under the nationalization plan and the grouping of hospitals under the control of regional boards will doubtless lead to elimination of smaller inefficient hospitals, and the planning of larger medical centers. At the present time one can inspect only older hospitals of prewar vintage. Generally, these are planned on the pavilion principle and in most cases wards are large, and there are very few instances where six and four bed wards have been adopted.

In many of the hospitals in the United Kingdom there is a noticeable use of high-class floor and wall finishes which in our country, and in some other countries, would be regarded as extravagance. One instance is the tiling of walls from floor to ceiling, where in other countries service rooms would not have walls tiled above the height of the door.

The standard of hospital equipment in the United Kingdom is lower than in some other countries, and less thought has been given to the development of labor-saving devices owing, no doubt, to the low wage scale in this country.

One interesting suggestion for the housing of female hospital staff, explained by an English architect as the "College Principle," is being considered. The proposal is to house graduate nurses, student nurses and trainees, lay, secretarial and domestic staff in dormitory buildings accommodating up to 100 persons in each building.

A number of such buildings would be grouped around an open park or garden and each building would provide only single bedrooms, bathrooms, laundries and small quiet recreation rooms. In the center of the area there would be planned a main building comprising administration, kitchen, dining rooms, and a variety of rooms for recreation. The scheme is considered practical and would be a great benefit to the institution in improving relations between the various grades of hospital staff. It is proposed to house different grades of staff in each dormitory building and that no individual building would be set apart for use solely by graduate nurses or any other group.

**Continental Hospitals:** One of the most striking features of hospital planning in Sweden and Switzerland is the extreme thoroughness with which administrators, architects and others investigate requirements of any new

SODERSJUKHuset, STOCKHOLM



hospital project. In several cases model rooms, wards and other sections have been built to full scale and tried out by various workers and by patients. Such experiments have led to many advances in the arrangement of hospitals and the equipment to be provided in new hospitals.

The simplicity of design and the elimination of any unnecessary detail, combined with the careful selection of materials and finishes, has placed some continental hospitals among the best in the world.

The use of color, of purpose-designed furniture and furnishings, the development of garden areas around the hospital, and the planting of flowers and small creepers in flower boxes within day rooms and solariums, are noticeable features in many European hospitals.

Cooking and sterilizing equipment in Switzerland particularly have been designed and constructed to the very highest standards.

The principle of taking patients in their beds or in specially constructed wheel chairs to bedpan or enema rooms, arranged near the wards, is gaining favor. This scheme eliminates the use of screens or curtaining in wards, and adds to the comfort of all patients, particularly of the one who is removed to the solitude of the bedpan room. The wheeled chairs are arranged so that they can be moved over the top of the standard W.C. bowl, being specially constructed for this purpose.

In several European hospitals elevators were planned on a decentralized system, and in addition to the normal bed passenger elevators, small elevators for the exclusive use of staff with a capacity of not more than six persons have been provided and add greatly to the efficiency of the hospital.

*Size of Ward:* Wards in hospitals, both on the Continent and in America, are considered too large if they contain more than six patients. Even in the large charity and free hospitals the tendency is to provide a large number of four bed or smaller wards to give extra flexibility in allotting the patients with regard to both disease and sex.

#### HOW DO WE IN AUSTRALIA STAND?

The more modern hospitals in Australia, built during the last 10 years, compare favorably in most respects with the average standard of hospitals in other countries. In construction



AMERICAN HOSPITAL, PARIS

there is little difference, but the range of materials available for finishing interior and exterior surfaces of buildings is much more limited here than overseas. Workmanship is not of such a high standard in Australia as on the Continent and in some parts of the United States.

In the field of hospital equipment, alas, we are a long way behind other countries—both in design and construction. This is due perhaps to the limited markets available to manufacturers, who have not the facilities for research and experimenting with new materials and methods. We are further handicapped by the extreme difficulties imposed on the importation of modern equipment, particularly from the United States of America.

In Australia there is no central authority or bureau where one may examine plans and general information concerning our hospitals. It is necessary to travel to each individual center and make detailed inspections in order to gain a knowledge of what exists.

It would be of inestimable value if perhaps the newly formed Australian Hospitals Association were to set up a research station to which those who

are interested could go to obtain the latest available information regarding modern hospital development.

#### CONCLUSIONS

In this postwar period there is a general desire in the world to plan for a better way of life, for better social conditions, for more community activities, and for the prevention and alleviation of sickness and misery among all peoples. In Europe, social legislation is directed towards the improvement of health in each community, and this will require more hospitals and the extension of health services.

Countries which have been fortunate in realizing their plans, and in building hospitals and other institutions in the years since war ended, have a great advantage over others which are still trying to get order out of chaos. In this period of planning and investigation of community needs, there is no more important matter than the collecting and sifting of the mass of hospital data which are available in most countries of the world to all those who take the time and trouble to search for it.

# COST STUDIES ANSWER THE CRITICS

H. M. WORTMAN, M.D.

Director  
Mountainside Hospital  
Montclair, N.J.

**D**O YOU know your costs? What are your costs? Is your school of nursing an expense to the hospital? You make money on your operating room, of course? How do costs in your laundry compare with commercial rates? Aren't your rates too high?

These and similar questions have been asked in recent years and will be asked more and more frequently as voluntary hospitals deal more and more with Blue Cross plans, insurance companies, governmental agencies, and so on. To have been able to answer these questions intelligently and accurately for the last 10 years has been a great satisfaction and has been most helpful to the trustees and the administrator of the Mountainside Hospital, Montclair, N.J.

## MUST KNOW COSTS

Unquestionably, the time has come when all hospitals must know their costs. Recognition of this need is shown in the programs of many of the state hospital associations and of the American Hospital Association to standardize methods of accounting, the recording of hospital statistics, and the allocation of expenses to determine costs. The New Jersey Hospital Association has such a project which is now at the end of its first year.

During this last year the state association, the Hospital Service Plan of New Jersey, and the hospital council of Newark have joined forces in financing the services of an accounting firm which specializes in hospital auditing, and a detailed manual of accounts has been developed and distributed to all member hospitals of the state association as the basis for the work of the second year. During the second year the staff of the auditing firm will meet with the bookkeeping and accounting staffs of hospitals individually or in groups to give instruction in the application of the uniform accounting system being developed. A second phase of the program will be to develop a system of allocating expenses for the development of cost figures.

At this point a word about expenses as contrasted with costs would not be out of order. It has been observed that hospital administrators, and others too, do not seem to understand or, if they do understand, to differentiate between "expense per patient day" and "cost per patient day." In general "expense per patient day" is derived by taking the total operating expenses for a given period and dividing it by the total patient days for that period. The "cost per patient day" is derived by allocating from total expenses during a given period that portion of those expenses applicable only to the inpatient services (*i.e.* excluding expenses incurred in conducting outpatient services for both clinic and private patients, emergency ward service).

Thus hospitals that provide a substantial amount of services other than inpatient services will have a much higher "expense per patient day" than "cost per patient day." This difference is widened if newborn infant days are evaluated in terms of a fraction of adult days (four infant days equal one adult day is a common ratio). To illustrate, the following tabulation is presented:

	EXPENSE PER PATIENT DAY		COST PER PATIENT DAY	
	Four Infant Days Evaluated as One Adult Day	Infant Days Equivalent of Adult Days	Adult and Children Days Only	All Patient Days ( <i>i.e.</i> Including Infant Days)
* Year ended Dec. 31, 1939	\$ 9.09	\$ 8.35	\$ 7.38	\$ 6.77
Year ended Sept. 30, 1948	\$17.27	\$15.55	\$15.00	\$13.46

It is easy to see how misleading "cost" and "expense" figures can be, unless they are properly defined and understood by all participating in a discussion on this subject.

The lack of understanding of the difference between these two terms can prove embarrassing to a hospital administrator.

Before proceeding with the presentation regarding costs it might be

well to state something about the Mountainside Hospital since costs will vary among hospitals, depending upon the type of community served by the hospital, the completeness of service provided, the presence or absence of a school of nursing, the amount of outpatient and "referred" services, and so forth.

Mountainside Hospital is a general voluntary hospital of 304 beds and 61 bassinets founded in 1890 and serving basically a population of 130,000 people in 11 communities varying in size from 1000 to 40,000. Private patients, however, come from a much broader area. Associated with the hospital is a school of nursing of about 100 student nurses. Extensive outpatient, emergency ward and private referred x-ray and laboratory services are provided in addition to the general inpatient services.

Part of the area is heavily industrialized, a small portion is agricultural but the greater part is residential where many live who work in New York City, only 15 to 20 miles away. It is an area of high living standards, where only the best is acceptable. The hospital has an excellent plant and facilities, a good medical staff, and over the years has provided good service and received good community support.

The first cost analysis was performed for the year 1939 and was done by

the auditing firm of the hospital which has specialized in hospital auditing and now audits about 40 hospitals in New Jersey, New York, Connecticut, Pennsylvania and Maryland (it is the same firm which is conducting the state association project mentioned previously). The administrative staff of the hospital assisted with the study and an exhaustive cost analysis was made, providing for the first time a knowledge of the

TABLE I.—COSTS PER PATIENT DAY 1939—1948

	1939	1943	1944	1945	Year Ended 9/30/48	Per Cent of Increase 1948 over 1939
<b>1. COST OF BED, BOARD AND ROUTINE CARE (Note 1)</b>						
Adults and children						
Private.....	\$ 7.11	\$ 6.86	\$ 7.46	\$ 7.66	\$11.35	60.2%
Semiprivate.....	5.61	6.04	6.25	6.41	10.08	79.7
Ward.....	4.96	6.52	7.00	7.45	11.57	133.3
Total—Adults and Children.....	5.69	6.43	6.78	7.01	10.77	89.3
Newborn.....	1.78	2.40	2.63	3.02	4.58	157.3
Total—All Patients.....	5.26	5.74	6.13	6.43	9.85	87.3
<b>2. COST OF SPECIAL SERVICES (Note 2)</b>						
Adults and children						
Private.....	1.84	2.40	2.46	2.81	4.18	127.2
Semiprivate.....	1.69	2.38	2.61	2.97	4.57	170.4
Ward.....	1.62	1.82	2.27	2.45	3.62	123.5
Total—Adults and Children.....	1.69	2.19	2.46	2.76	4.23	150.3
Newborn.....	1.51	1.82	2.07	2.36	3.61	139.1
Total—All Patients.....	1.51	1.82	2.07	2.36	3.61	139.1
<b>3. TOTAL COSTS (INCLUDING SPECIAL SERVICES)</b>						
Adults and children						
Private.....	8.95	9.26	9.92	10.47	15.57	74.0
Semiprivate.....	7.30	8.42	8.86	9.38	14.65	100.7
Ward.....	6.58	8.34	9.27	9.90	15.19	130.9
Total—Adults and Children.....	7.38	8.62	9.24	9.77	15.00	103.3
Newborn.....	1.78	2.40	2.63	3.02	4.58	157.3
Total—All Patients.....	6.77	7.56	8.20	8.79	13.46	98.8

NOTE 1. Costs shown above for Bed, Board and Routine Care have been further analyzed as to the applicable cost of the following individual items:

1. Depreciation of furniture
2. Patients' meals
3. Power plant and general house and property
4. Laundry
5. Linen and bedding
6. Housekeeping
7. Graduate nursing
8. Student nursing
9. Nursing attendants
10. Interns and residents
11. Medical and surgical supplies and expense
12. Central supply room
13. Pharmacy and miscellaneous professional care
14. Social service
15. Admissions
16. Administration

NOTE 2. Costs shown above for Special Services have been further analyzed as to the applicable cost of the following individual services:

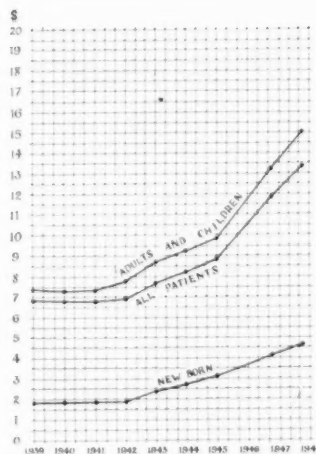
1. Operating room
2. Delivery room
3. X-ray
4. X-ray therapy
5. Laboratory
6. Physical therapy
7. Oxygen therapy
8. Emergency room
9. Ambulance
10. Electrocardiograph and basal metabolism
11. Cost of drugs sold
12. Cost of solutions sold
13. Blood bank

The increase in costs per patient day between 1939 and 1948 cannot be attributed entirely to rising or inflationary costs which occurred during this period. Other factors, such as introduction of new and costly drugs and other forms of treatment, early ambulation, and shortening of the average period of hospital stay are definite factors increasing the cost per patient day over and above any increase which can be attributed to general increase in "cost of living." In other words, cost per patient stay has not increased relatively as much as the cost per patient day. The increase in cost per patient day is relatively higher because of more costly and a more concentrated service provided per patient stay with little or no hospital "convalescent" period, in 1948 compared with 1939.

cost of operating the various services of the hospital. Average unit costs for the following services were obtained:

1. Patient Day Costs
  - Private
  - Semiprivate
  - Ward
  - Newborn
2. Operating Room per operation
3. Delivery Room per delivery
4. Outpatient Department per visit
  - Basic cost
  - Including x-ray, laboratory and drugs
5. Emergency Ward per treatment
6. Physical Therapy per treatment
7. Laboratory per treatment
8. X-Ray per examination
9. Ambulance per trip
10. Meals
  - For patients
  - For employes
11. Laundry per pound
12. School of Nursing per student per year

Since 1939 similar cost studies have been made for the calendar years 1943, 1944, 1945 and for the year ended Sept. 30, 1948. For the years 1940, 1941, 1942 and for the nine months



Graph 1. Total Costs per Patient Day 1939 - 1948

ended Sept. 30, 1947, estimated costs were determined, using certain "short cuts" but applying principles used in the actual cost studies. In Table 1 are shown the comparisons of costs per patient day for the years 1939, 1943, 1944, 1945 and the year ended Sept.

30, 1948. Graph 1, however, includes not only the actual cost figures for these years, but in addition, the estimated costs for the years 1940, 1941, 1942 and the nine months period ended Sept. 30, 1947.

As successive cost studies were made, certain refinements were developed and emphasis would be placed on special cost determinations.

For example, in the cost study for 1945, it was felt desirable to subdivide the private, semiprivate and ward categories into medical and surgical, maternity and pediatric services in order to determine relative costs of these respective services. Some interesting and illuminating results were obtained. For instance, it was shown that the patient day cost of mothers in the maternity department was substantially higher than that for either the medical or surgical adult patients or for the pediatric patients, and—something which we had not suspected—the cost per day for pediatric patients was fully as much as that for medical or surgical adult patients and in some categories even greater.

(Continued on Page 124.)

## The problem of

# MEDICAL RECORDS

## is still a problem

THE average hospital of 75 to 100 beds would appear to have one full-time medical record librarian, trained by attendance at an institute but lacking full professional status; her work is hampered by inability to get full cooperation from all members of the medical staff; usually she is permitted to issue reminder notices to staff members whose records are delinquent, but only rarely is she backed up with real disciplinary action against delinquent members. This is the figure that emerges from a survey of medical record operations in 26 hospitals ranging from 28 to 113 beds.

### FIVE HAD NO LIBRARIAN

The hospitals were located in all sections of the country and all types of community. The average size of the hospitals covered in the forum was 70 beds. Only five hospitals in the group did not employ a full-time medical record librarian, it developed. In one or two instances the full-time librarian had one or more assistants doing clerical or stenographic work in the medical record library.

In the cases where the librarian's duties were only part time, the usual arrangement had her doing general office work in addition to library functions. In one or two cases the librarian was a member of the nursing staff.

The monthly salary of medical record librarians in these hospitals ranged from \$120 to \$225. The average was \$162. In four cases, including the \$120 librarian, the cash salary is supplemented by meals or other maintenance perquisites, it was indicated.

A comparatively small number of the full-time librarians working in these hospitals have had full-time medical record librarian training, it was reported. On the other hand, only eight of the librarians had no

special training at all in library work. The remainder had had some form of condensed study or institute training or, at least, on-the-job training from a trained librarian.

The need for additional professional training for these librarians was one of the features that emerged strongly from the reports. Only six administrators in the group felt that the librarians in their hospitals did not need some additional training; in most cases, it was indicated, some form of concentrated medical record library instruction was needed. One administrator felt that the librarian should have special training in statistical work; several mentioned the need for training in nomenclature; other needs that were specifically mentioned included administrative training, filing and "staff relations."

All but five hospitals in the group acknowledged that they had some trouble getting staff doctors to complete their clinical records. Asked what feature of the record seemed to offer the most trouble the administrators named histories, progress notes, pre-operative diagnosis, physical examinations, and operative records. In most cases, some systematic reminder system is being used to prod delinquent doctors into completing their records. It was acknowledged by many, however, that these methods were producing only fair results.

Two hospitals described their systems under which delinquent doctors were charged fines. In one case a 50 cent charge is made for any record that is more than two weeks old at the time of the regular medical staff meeting. The other hospital was just inaugurating a system of fines and had no experience to report.

Five hospitals in the group had obtained board action making it possible

for the administrator to refuse admission to patients of doctors whose records were delinquent.

This measure was deemed unnecessary by at least one of the respondent administrators who felt that it was necessary only to let the doctors know that the hospital standing with approving authorities is jeopardized by delinquent records.

"We wrote letters to each doctor telling him how many incomplete records he had," this administrator reported. "We told them that we had made a professional audit of the hospital on an American College of Surgeons report form and found that we were in pretty good shape except for medical records. Copies of the letter were sent to the executive committee of the hospital board. We were not being dictatorial but were only trying to do what we felt they wanted us to do—keep the hospital approved. I was amazed at the response. The staff accepted its responsibility. I refused to worry about records. It is the responsibility of the medical staff and I believe it will do a good job if we give it the responsibility."

### DICTATING MACHINES HELP

Others reported that records had been improved by the installation of dictating equipment and stenographic help, making it more convenient for doctors to complete operative reports and clinical summaries promptly. However, the emergent opinion seemed to be that whatever follow-up or disciplinary measures were adopted, the problem would probably continue to be troublesome.

"The American College of Surgeons and the various specialty boards might consider aiding us with the hospital record problem," one administrator commented. "Some of our worst offenders from the standpoint of delinquent and inadequate records are college and board members. The attitude 'The King can do no wrong' is all too prevalent."

Only four hospitals in this group have microfilmed records at the present time. However, several additional hospitals indicated that microfilming was contemplated and felt that it was a practical solution for the small hospital.

# MEDICAL RECORDS IN SMALL HOSPITALS

REGION	BEDS	LIBRARIAN	SALARY	TRAINING	TRAINING NEEDED	DELINQUENT DOCTORS	CORRECTIVE STEPS	MICRO- FILM	Clinical Records	TIME RECORDS ARE KEPT			Tr. to Inactive File
										Nurses'	X-Ray	Negatives	
East.....	52	F	\$120 +	none	condensed MRL	yes	Reminders	no	Indefinitely	Indefinitely	Indefinitely	Indefinitely	1 year
East.....	90	F	200	yes	none	yes	Reminders	no	Indefinitely	Indefinitely	6 years	Indefinitely	5 years
East.....	85	2F	170	yes	none	some	Fines	no	Indefinitely	Indefinitely	Indefinitely	Indefinitely	1 year
East.....	92	F	150 +	yes	statistics	no	Discipline	no	20 years	20 years	7 years	7 years	3 years
East.....	62	F	160	yes	statistics	no	Discipline	yes	20 years	20 years	3 years	3 years	1 year
East.....	50	P	143	on-job	MRL	no	Discipline	no	Indefinitely	Indefinitely	Indefinitely	Indefinitely	1 1/2 years
East.....	70	F	150 +	yes	none	some	Discipline	no	Indefinitely	Indefinitely	5 years	5 years	5 years
Midwest.....	80	F	200	yes	MRL	yes	Reminders	no	25 years	10 years	10 years	10 years	1 year
Midwest.....	75	1F, 1P	140	on-job	none	yes	Reminders	no	Indefinitely	Indefinitely	6 years	6 years	all active
Midwest.....	113	F	200	RN	condensed MRL	yes	Reminders	no	Indefinitely	Indefinitely	7 years	7 years	1 year
Midwest.....	65	F	140	condensed	on-job	yes	Reminders	no	Indefinitely	Indefinitely	20 years	20 years	3 years
Midwest.....	70	F	200	MRL	none	some	Discipline	no	15 years	15 years	5 years	5 years	3 months
Midwest.....	94	F	145	none	MRL	yes	Discipline	yes	Indefinitely	Indefinitely	5 years	5 years	6 years
Midwest.....	35	F	130	none	MRL	yes	Reminders	no	Indefinitely	Indefinitely	10 years	10 years	6 years
South.....	80	F	150 +	some	MRL	yes	Reminders	no	Indefinitely	Indefinitely	5 years	5 years	5 years
South.....	84	F	160	yes	MRL	yes	Reminders	yes	Indefinitely	Indefinitely	5 years	5 years	1 year
South.....	64	F	200	no	MRL	some	Reminders	no	10 years	10 years	10 years	10 years	5 years
South.....	25	P	109	no	MRL	no	Reminders	no	Indefinitely	Indefinitely	Indefinitely	Indefinitely	5 years
South.....	80	2F	170	condensed	condensed	some	Reminders	no	Indefinitely	Indefinitely	5 years	5 years	1 year
South.....	36	F	145	no	MRL	yes	None	no	Indefinitely	Indefinitely	Indefinitely	Indefinitely	5 years
South.....	55	F	225	MRL	adm.	no	Discipline	yes	Indefinitely	Indefinitely	Indefinitely	Indefinitely	5 years
West.....	28	P		RN	MRL	yes	Reminders	no	Indefinitely	Indefinitely	Indefinitely	Indefinitely	all active
West.....	50	F	175	yes	none	some	Reminders	no	Indefinitely	Indefinitely	10 years	10 years	all active
West.....	90	F	150	yes	condensed MRL	yes	Reminders	no	Indefinitely	Indefinitely	3 years	3 years	immediately
West.....	75	P		yes	condensed MRL	no	Reminders	no	Indefinitely	Indefinitely	Indefinitely	Indefinitely	10 years
Canada.....	100	P		no	condensed MRL	yes	Reminders	no	20 years	20 years	9 years	9 years	all active

F = Full-time  
P = Part-time

# About People

## Administrators



Dr. J. C. Doane

**Dr. Joseph C. Doane**, for 21 years medical director of Jewish Hospital, Philadelphia, has resigned to devote his time to private practice. Dr. Doane is a charter fellow of the American College of Hospital Administrators, past president of the American Hospital Association, and past president of the Pennsylvania Hospital Association and the Philadelphia Hospital Association. He served as editor and later as chairman of the editorial board of *The Modern Hospital* for many years. He has been succeeded at Jewish Hospital by **Dr. I. Oscar Weissman**. Dr. Doane will serve the hospital as educational director.

**A. K. Besley**, former superintendent of Prince Georges General Hospital, Cheverly, Md., has accepted the position of assistant superintendent at Western Pennsylvania Hospital, Pittsburgh. Mr. Besley's position at Cheverly has been taken over by **Harry A. Penn Jr.**, former assistant superintendent at the hospital. **David McNamee** has been appointed assistant to Mr. Penn.

**Capt. John T. Bennett**, a retired naval medical officer, is now administrator of Crozer Hospital, Chester, Pa.

**T. A. Bravos** has resigned as assistant superintendent of Community Hospital, San Mateo, Calif., to become business manager of Sonoma State Home, a 3300 bed mental institution in Eldridge, Calif.

**Dr. Edward A. Piszczek** has taken a year's leave of absence as director of the Cook County (Ill.) Health Department to take over the post of controller for the suburban Cook County tuberculosis sanitarium district.

**William T. Lees Jr.** has succeeded **Amy E. Birge** as administrator of Cooley Dickinson Hospital, Northampton, Mass. Miss Birge retired after more than 30 years in the hospital field. Mr. Lees has been assistant administrator at the hospital since March 1948 and prior to that time was administrator of Children's Hospital, Portland, Maine.

**Harvey Schoenfeld** has been appointed assistant director of Maimonides Hospital of Brooklyn, N.Y. Mr. Schoenfeld has been resident management engineer and director of personnel at St. Vincent's Hospital, New York City, for the last three years.

**Mrs. Edith Masterman** has been appointed administrator, Bangor City Hospital, Bangor, Maine.

**W. Conant Faxon**, who has been serving as administrator, Concord Hospital, Concord, N.H., is no longer associated with that institution.

**Eva E. Dean** has retired as administrator, Moses Taylor Hospital, Scranton, Pa. Miss Dean had completed 11 years of service with that institution.

**Frederic E. Charrier** has resigned as administrator, Henrietta D. Goodall Hospital, Sanford, Maine.

**Fannie Fox** has resigned as director of nursing service, General Rose Memorial Hospital, Denver, to accept the position of administrator at Texas Elks Children's Hospital, Ottine, Tex.

**Dr. Lloyd B. Andrew**, chief of professional services at the Veterans Administration Hospital, Jackson, Miss., has been named manager and chief of professional services of the new Veterans Administration Hospital at Big Spring, Tex. The hospital is scheduled for completion in March.

**Dr. Morley B. Beckett's** appointment as manager and chief of professional services of the Veterans Administration Hospital now under construction at Saginaw, Mich., will become effective in February. Dr. Beckett has been associated in medical administrative positions in the state of Michigan for more than 15 years.

**John A. Schaffer** has succeeded **Lee W. Wolfe** as assistant administrator of Reading Hospital, Reading, Pa. Mr. Schaffer received a master's degree in hospital administration from Northwestern University, following the completion of his residency at Reading Hospital. He served as administrator of Ephrata Community Hospital, Ephrata, Pa., from April 1 until his appointment at Reading.

## J. Walsh Stull

has been appointed administrator of the new Memorial Hospital at Charleston, W. Va. A graduate of Columbia University, Mr. Stull took his master's work in hospital administration at Northwestern University, where he also was assistant to the director of Wesley Memorial Hospital. Mr. Stull's experience includes several years with Ross Garrett and Associates, hospital consultants.



J. Walsh Stull

**George A. Collins** assumed the position of administrator at Alameda Hospital, Alameda, Calif., following the resignation of **Ruth A. Wescott**.

**Jacques Cousin** has been appointed assistant director of the Council of Rochester Regional Hospitals, Inc., Rochester, N.Y. A graduate of the course in hospital administration at Columbia University, Mr. Cousin served his administrative residency at Harper Hospital, Detroit, where he has held the position of assistant director for the last year and a half.

## Department Heads

**Guy Condon**, formerly purchasing agent for Presbyterian Hospital, New York City, has been appointed purchasing agent for the New Rochelle Hospital, New Rochelle, N.Y.

**Mrs. Dorothy Hitchcock** (formerly Mrs. Dorothy Carrington) has joined the staff of East End Memorial Hospital, Birmingham, Ala., as director of nursing service. Mrs. Hitchcock was director of nursing service at Hillman Hospital, Birmingham, and at one time was superintendent of nurses at Baptist Hospital, Selma, Ala.

**Adelaide A. Hughes, R.N.**, has been named acting chief of the central office neuropsychiatric nursing section of the Veterans Administration, succeeding **Letitia Wilson**, who is returning to her position as director of nursing service in the psychiatric department of Pennsylvania Hospital, Philadelphia. Mary

(Continued on Page 164.)

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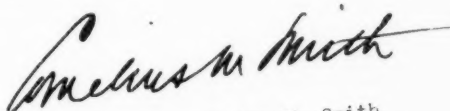
To Administrators  
And Trustees Planning  
Expansion Programs

A decade rich in promise for America's voluntary hospitals is at hand.

Thirty years of successful practice, devoted wholly to hospital finance, has equipped Will, Folsom and Smith with an unmatched body of experience. The new high records set in our post war projects particularly qualify us for the greater programs of the mid-century.

Since Pearl Harbor, 101 capital funds for hospitals ranging from \$150,000 to \$20,000,000 have been entrusted to our management. Their objectives total \$140,000,000. Although more than a dozen are still to be completed, \$114,000,000 already has been subscribed.

Hospital fund-raising movements under the direction of our staff of specialists are now scheduled well into the next year. Your hospital's program will have our careful study when you are ready to discuss it with us.



Cornelius M. Smith  
President

## BUT WHAT ABOUT THE PUBLIC?

**T**OO frequently, in considering problems affecting our hospitals, our doctors and trustees, we overlook the very reason for their existence—the public. So engrossed do we become in the professional and administrative procedures of our individual institutions that we fail to take time out to ask: "Are we giving our American public the type of hospital and health care it needs and has a right to expect? Despite the lofty phrases with which we uphold our voluntary pattern, is this public utility, this commodity we are offering, cut to the needs of our people? Is it all-inclusive, is it available to all and at costs they can afford to meet? And is it being properly presented, merchandised, so to speak?"

Were these questions to be put to public vote, there would be agreement, no doubt, that our present pattern of health and hospital care, while far above that of other countries, is not filling the bill, is not meeting our complete requirements. Very well, then, what are we going to do about it?

### WHAT DO WE HAVE TO OFFER?

The more we besmear government competition, the more logically the public inquires: "What have you to offer that is better?" Which starts us again on eulogies of our voluntary hospital system and its great contributions, but with nothing about the future, nothing that is definite or reassuring. Quite to the contrary, we confess to fears that we will not be able to survive.

But does our hope of survival rest in dwelling upon what's wrong with government domination of hospital and health service, or in concentrating upon what is wrong with our own

From a paper presented at the American Protestant Hospital Association meeting, 1949.

RAYMOND P. SLOAN

product, and what can be done about developing it and modernizing it to the point where it will meet our social needs. Clearly we have need to go to the public with something tangible, something about which we can say with conviction: "Yes, we have something that is better. Here it is. Let us tell you what it will do for you."

This may appear to have a commercial connotation, but are we not constantly hearing of hospitals being compared to big business? Hospitals are big business: they're big business "plus," and it is justifiable to interpret them as such, provided we never overlook that "plus." Sometimes I become fearful that we are doing so, and in consequence are losing the motivating power of our great institutions, the power that is borne of the heart and the soul, the power that comes from true religious faith.

But for the moment, let's think in terms of business. Faced with a product that apparently is not measuring up to requirements, business gets busy and does something about it. It proceeds to pull that product apart, to find out what's wrong with it. First, it determines what are its consumers' needs. Then it assembles company directors, general managers, department heads, engineers, merchandising experts, who study day and night to make sure they have the answer, something that will meet those needs. Before arriving at any final decision, they conduct extensive research in various areas to determine what will be the consumers' reaction to the product.

Isn't that a sound pattern for us to follow in handling our own com-

modity which is hospital and health service? Why shouldn't we place this commodity on the table, so to speak, call in everyone concerned—hospital heads, public health officials, doctors, trustees, with representative citizens—and proceed to take it apart?

We learned, those of us who took the time to study the report of the Commission on Hospital Care, that we have no hospital system as such. To quote from that report: "Governmental units, church bodies, philanthropists, industries and individuals have participated in the construction of hospital facilities. The diversity of background and objective of those sponsoring interests have resulted in widely disparate patterns of organization, administration and control of hospitals. In some instances there may even be competition."

### FORGET ABOUT OURSELVES

To develop a hospital system that will meet the requirements of all demands study, planning. It means we must quit thinking about ourselves, our own beliefs and ideas and start doing some thinking about others.

Boards of trustees, medical staffs and auxiliaries meet on occasion to discuss their precise functions, and to seek guidance in their specific problems. But it is always their specific problems that are involved. Seldom is there any indication that they are studying their institution in its relationship to an over-all health and hospital system.

If we are serving as trustees, let's try to start thinking inwardly, instead of outwardly. Let's forget that we are trustees or guardians of the health of some of the people, but remember instead that we are guardians of the health of all of the people. Let's con-

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tinue to think and to plan for our own institution by all means, but not solely as our own institution. Our hospitals no longer belong to the few. Today they are sustained by and are part of the community. Let's measure our hospital's services, then, not by its accomplishments alone, but by its accomplishments in conjunction with other agencies.

This is not so easy as it may sound. It is going to hurt to change our by-laws, to appear to throw to the winds all of our worthy traditions. But times change and we must change with them. Isn't it better to effect such changes ourselves, than to move out altogether and have someone else step in and take over? And we know who that someone will be.

This implies that those who are our policy makers, our trustees, must acquire broader perspectives. This is no time for them to become concerned with petty details of administration. Let them hire a competent administrator and give him or her the privilege of worrying about the bulb snatching that goes on. Our trustees might well do less "inspecting" and more overall planning.

#### LET'S ABANDON POLITICS

If we happen to be doctors, let's abandon our petty politics and prejudices and get to thinking more about the patient. There are the miracles we perform, some of us, on our own patients. But what about the patients of others—all patients? Sometimes it would appear that no one had patients other than ourselves. What we need is less rugged individualism and more group effort.

And above everything else, let's stop kidding ourselves that we are the boys who should be running the hospital, and not that board of stodgy old men who know nothing about professional requirements. Let's agree that if we do well the jobs for which we are trained, we'll have enough to keep us occupied. And instead of crying over socialized medicine and keeping ourselves and everyone else in the staff room stirred up, let's come forth with something better—a more efficient product.

If we're hospital people, administrators particularly, let's acknowledge our faults. For like everyone else, we have them, plenty of them.

Let's admit that we haven't paid as much attention as we should to public attitudes. Let's admit that we haven't

always been as successful business managers as we might, that there are loose ends which need tightening, waste which might be eliminated. Our responsibility is no longer to the two or three individuals who kept us going in the past, but to the public. It is the public's money we are spending, not our own.

We have at our disposal today educational advantages hitherto undreamed of. Formerly we governed our hospitals chiefly with heart and soul; today we reach for the slide-rule. It is better for us, financially, but is it better for the patient, and lest we forget, it is the patient who does, or should, count. Were his opinion to be asked, the patient, no doubt, would favor less "slide-rule" and more "soul."

#### WHAT WILL WE DO WITH IT?

What are we going to do with all this education we are acquiring? Are we going to use it as a springboard to project ourselves before the world, thus furthering our own ambitions? Or are we to employ it as a device through which we can become more successful members of the team that is going to carry us to the desired goal—a better hospital and health plan.

Education is what we make of it. It can serve as a spur to our selfish ambitions. It can feed our desire for personal advancement, causing us to jump from this hospital post to that because of a more alluring name or bigger bed capacity. But, remember, it isn't always the individual with the big hospital affiliation, the one who talks loudest or longest, who is making the greatest contribution. The little fellow in the small hospital may be doing a bigger and a better job.

The truth of the matter is that many of us, while becoming more proficient in our individual tasks, are becoming less efficient in group formation. Where we should be selfless, we are selfish.

Assuming we are agreed upon the necessity of changing our personal attitudes and ways of thinking, we must now proceed to study this product, this package comprising an over-all hospital and health plan from the standpoint of others. Let the doctor envision it through the eyes of the trustees and the administrator; the trustee envision it through the eyes of the doctor and the administrator; the administrator envision it through the eyes of the trustee and the doctor. And above everything let us jointly envi-

sion our product through the eyes of the patient.

What's wrong with it? Many things, obviously—high costs, poor distribution of facilities, lack of unification or centralization, waste—to mention a few.

Having developed some unified thought, let's continue. What are the consumer's requirements? What will fill his needs? What does he want?

Commercial organizations, before risking their capital and efforts in launching a new product, spend months, years even, testing it out, getting consumer reaction, making sure that it is cut to the right pattern. If it is worth all this effort to launch a commercial product, how much more necessary is it to anything so vitally important as health!

Once assured the product is right, there is its packaging. It must be effectively presented. Furthermore, once sold, it must be kept sold. For competition doesn't cease once we've struck home.

We need to back up this new product with the most comprehensive educational campaign we can muster. That is where we've been notably weak in the past. We've never unanimously and concertedly told the hospital story. To be sure, we've worked ourselves into a frenzy winning friends and influencing people when we've wanted their cash, but we don't seem to have over-exerted ourselves at other times.

#### ALL SPENT ON FUND RAISING

We've been known to spend literally millions of dollars upon elaborate brochures describing hospital needs which we have placed in the hands of trustees and other workers during fund-raising campaigns. But little thought has been given to preparing similar material for use by trustees and others in interpreting hospital service at other times. Instead of waiting until we hear the cries of the wolf at our front door, why not strive to keep him beyond howling distance.

"And the public." There it is, waiting to be told what we have to offer. While it waits, it looks at that package which the government dangles enticingly before its eyes. And for the most part, it likes what it sees.

"And what have you to offer that will do as much for as little?" That is the question the public is asking.

That is the question before us. What are we going to reply?

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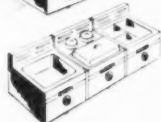
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## EVOLUTION OF A CANCER RESEARCH PROGRAM

IAN MacDONALD, M.D.  
Los Angeles County Hospital  
and the Department of Surgery  
School of Medicine  
University of Southern California

FOR 16 years the American College of Surgeons and the American Cancer Society have fostered the development of cancer clinics in general hospitals, large and small, and today almost 500 hospitals in the United States and Canada conduct cancer clinics approved by the college.

The benefits of a formal plan of consultative management in the formidable group of diseases which we call cancer should require no reiteration here. The solo treatment of cancer has become an impossibility; neoplastic diseases overlap virtually every conceivable branch of medicine in an age of expanding specialization.

### INDICATES RANGE OF SCIENCES

The word "oncology" aptly indicates the range of sciences which touch on the cancer problem, and they include genetics, embryology, inorganic and biochemistry, physics with its new fledgling the fissionable family, microbiology and most of the other so-called preclinical sciences, as well as the arts and sciences of pathology, surgery, radiology, biometrics and the like.

To match the designation "oncology" with one signifying individual mastery of its wide range by an "oncologist" is a severe strain on human capacity and even on human credibility, and would exceed the temerity of a Leonardo da Vinci. It seems probable, and to us desirable, that no more than a small fraction of cancer patients will be cared for in special cancer hospitals, their logical and proper function being in graduate training of cancer therapists for key positions, in development of new methods of treatment, and especially in research.

To apply expanding clinical knowledge with maximum effectiveness for the greatest possible number of cancer patients requires a superlative integration of service in the large general

hospital. The larger the institution, the greater the case load, the more disorderly the treatment of cancer may become under individual clinicians and separate departments.

Conversely, the integration of cancer diagnosis, treatment and follow-up in the general hospital produces proportionately greater benefits with larger numbers of patients. When such a hospital is also an integral part of a medical school, the responsibilities of undergraduate education are added to those of graduate training of interns and residents. In no conceivable fashion can these obligations in clinical care and medical education be solved in the large hospital other than by an organized cancer service. Failure to obtain maximum effectiveness in all phases of the cancer problem by voluntary and existing tax supported hospitals is an open invitation to concentration of patients in special institutions under state control.

The Los Angeles County Hospital is an institution in which an extensive integration of cancer service has developed by slow evolution over a period of 26 years. In 1922 the treatment of cancer had become a matter of heated debate in this hospital, chiefly among certain advocates of cold knife surgery, cautery surgery and radium, and it will not be a surprising admission that differences of opinion on such matters still exist and indeed add considerably to the clinician's interest in certain problems that as yet remain unsettled.

Rather than continue their therapeutic feud from entrenched departmental positions, a small group of interested clinicians decided to act as a consulting group with weekly sessions and to review jointly diagnostic

problems and determine therapeutic methods for individual patients. The group enlisted the support of the hospital's chief pathologist, who became an active member of the group and learned to examine living patients and see pathologic processes *in situ*, as well as demonstrating by projection for the group each week the microscopic slides of current cases.

In short, the second formally organized group cancer clinic was thus born in 1922, and its birth represented the attempt of honest though sometimes prejudiced clinicians to bring some order out of therapeutic chaos. The group designated itself as a "tumor board" rather than a cancer clinic, and this linguistic twist seemed to set a nomenclatural pattern for California to the extent that the California Cancer Commission now uses the expression "tumor board" as official jargon for "cancer clinic," and it has been copied even in some of the more effete sections of the United States.

### TUMOR BOARD ORGANIZED

The tumor board was organized with an official independent status, its members appointed by nomination from the board itself but subject to confirmation by the medical advisory board. The Los Angeles County Hospital is the teaching hospital for two medical schools, University of Southern California School of Medicine and the College of Medical Evangelists.

The clinical departments of the hospital are divided between the two schools, so that there are matching clinical services in all clinical departments under each school, and appointment to the medical staff of the hospital has as a prerequisite appointment to one of the medical school faculties, but is subject to approval by the medical advisory board of the hospital. The organization of the tumor board was

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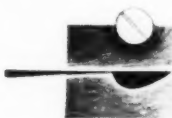
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Suspension, 0.5 Gm. per 5 cc.  
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followed by the development of tumor surgery services, one for each medical school.

For some years there was a third tumor surgery service on which cautery surgery was used exclusively, but as this method proved to have no superiority over cold knife technic except in occasional forms of cancer, the service was finally discontinued.

During the first decade or more, the tumor board attempted to determine the relative value of different therapeutic methods in specific forms of cancer, such as surgery and irradiation in uterine and breast cancer. In spite of limitations imposed by lack of adequate follow-up, but with the advantage of the pooled knowledge of a group conversant with current concepts, it became possible for the tumor board to establish certain criteria which have proved of enormous value in so large an institution.

#### AGREED ON TREATMENT

For example, the extent of involvement or "clinical stage" of a certain form of cancer usually determines the prognosis and type of treatment to be employed, and certain major forms of cancer in specific anatomic sites were soon being sorted out with clinical accuracy. Eventually the members of the group acquired a large enough experience based on joint observation of the efficacy of therapeutic methods to agree on standard types of treatment for specific stages of certain forms of cancer. Uniform methods of staging and treatment were determined at special sessions of the board, and were and are so revised in the light of further experience and development of new technics.

Except for the addition of a follow-up clinic, the tumor board continued to conduct a single weekly session until 1941. The patient load had become increasingly great with the growth of the hospital and the growing prestige of the board, requiring sessions of from four to six hours' duration. Many patients required only adequate examination, accurate diagnosis and referral for an accepted plan of treatment, and thus the time of the group was being dissipated in routine. Further, no part of the large volume of patients was being utilized in undergraduate teaching.

In 1941 a reorganization was accomplished, the most important phase of which was the initiation of a "New Patient Clinic." To this clinic come

the new patients direct from the admitting department and patients referred from other clinics and services in the hospital. It is conducted by the head of radiation therapy in the hospital, by one or more representatives of the tumor surgical team on service and usually with a surgical pathologist present.

Residents and interns from tumor surgery and radiation therapy are responsible for preliminary work-up and presentation of patients. The radiation therapist, as a permanent member of the clinic, is in charge. The permanent secretary attached to the tumor board takes dictation, and the nursing personnel is provided from the outpatient department.

This clinic has full authority in allocating patients to proper services for treatment, and only problem cases or those of particular interest are referred to the tumor board proper. The majority of new patients are thus sent directly to tumor surgery, radiation therapy or an appropriate service for treatment, either by admission to the hospital or as outpatients.

Operating concurrently with the "New Patient" is the "Follow-Up Clinic" conducted by the tumor surgical services, and the two services alternate weekly between the two clinics, thus giving the surgeons an opportunity to see and evaluate their own end results and intelligently manage complications and recurrences. Radiation therapy conducts its own follow-up clinic, referring patients in whom surgical indications arise either to the tumor board or the surgical follow-up clinic. The average case load at the new patient clinic varies from 20 to 30 and at the follow-up clinic, 30 to 50, weekly.

Small groups of senior students from both medical schools attend these clinics. Under the plan for U.S.C., student groups of 10 or 12 senior students are assigned for three hours weekly for six weeks, alternating between the new patient and follow-up clinics. They have opportunities for examination of patients, and see a wide range of tumors of the skin, head and neck, breast and extremities. The student obtains a firsthand impression of diagnostic aids, evaluation of treatment, both palliative and curative, for individual patients, and sees also the end results of treatment both immediate and late.

With this reorganization the tumor board was able to undertake a more

orderly and deliberative course, reviewing the problem cases filtered through from the new patient clinic, patients referred from either of the follow-up clinics, and consultation problems from other hospital services. The sessions are attended by from eight to 10 of its 16 members in any given week, and occupy from one and one-half to two hours.

During the first 15 to 30 minutes of each session the surgical pathologist for the cancer service reviews the biopsy and operative material from the preceding week by projection of color films of gross material and microscopic sections. In the interval of two days between the new patient clinic and this session, biopsies have been sectioned and diagnostic x-ray work has been done on patients to be seen by the board. A roentgenologist assigned to the board is present to demonstrate and report films. One social service worker is permanently assigned to the cancer service and attends each board meeting, helping to work out patients' problems for hospital care, outpatient visits and placement. Clinical photography is used unsparingly.

#### SOURCE OF EDUCATION

These sessions are a source of continuing education for physicians interested in cancer. Residents and interns other than those attached to the cancer service attend regularly in considerable number. Occasional members of the attending staff from other departments sit in. There are frequent visitors unattached to the staff of the hospital, especially surgeons and radiologists from outlying communities as well as from the metropolitan area.

During the subsequent war-time years the modified plan of operation greatly facilitated the conduct of the cancer service with a skeleton staff. The actual care of patients had reached a satisfactory level at this stage of development, but there remained certain obvious defects in terms of a long-range program.

The most distressing deficiency was in follow-up. If patients failed to attend the follow-up clinics, no mechanism existed to ensure their return or even to obtain information. With a transient population of variegated racial origin, the follow-up was a dismal 20 per cent. Even this figure was a "guessimate," based on a few attempts which had been made to evaluate statistically end results in certain forms of cancer.

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Ammonium Chloride	12 gr.
Sodium Citrate	2 gr.
Chloroform	2 gr.
Menthol	1/10 gr.

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Another defect was the absence of a special registry for cancer cases. In a hospital with an average daily census of 3000 patients and 370,000 outpatient visits yearly, accessibility to and review of records of some particular problem is difficult, even with a mechanical punch-card system.

The potential importance of the hospital cancer service in an expanding program for cancer control in California soon became apparent, and served as a further stimulus to develop a more effective integration of all activities in the hospital related to can-

cer. The California Cancer Commission was undertaking an extensive program in postgraduate education. The division of chronic diseases in the state department of health was developing plans for a tumor registry, with selected hospitals to be chosen for co-operation in a pilot plan trial.

The anticipated postwar influx of candidates for graduate training pointed up the desirability of organizing teaching collections of well prepared material from the cancer services. Finally, there were a few research projects in cancer under prosecution,



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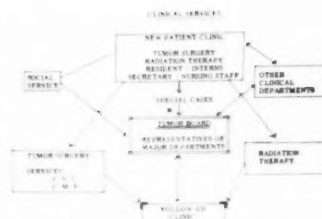
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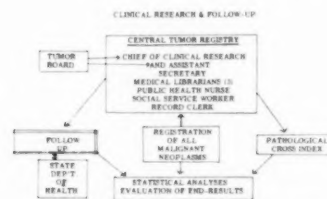
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**Fig. 1. Clinical cancer services. Los Angeles County Hospital**



**Fig. 2. Over-all plan of cancer service**



**Fig. 3. Clinical research and follow-up**



**Fig. 4. Education**



**Fig. 5. Research**

some clinical in nature and others more fundamental. These and other contemplated research projects requiring financial aid from various sources



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suggested the desirability of lending support to qualified applicants under a correlated program.

In 1945 a small group acting as an executive committee for the tumor board developed a plan to achieve these multiple objectives, outlined in abstract in figure 2. Only the clinical service portion (figure 1) was an actuality and the remainder of the program fell naturally under three headings: (1) follow-up and clinical research, (2) education and (3) research.

The detailed outlines of these three

phases as developed at present are seen in figures 3, 4 and 5. A grant of \$25,000 was obtained for the year 1946-47 from the California division of the American Cancer Society, with the support of the California Cancer Commission. Priority was given to establishing an adequate follow-up system and to postgraduate education.

An adequate follow-up system in a hospital of this size demanded a central tumor registry which is the core of this phase of the program. The work of the registry is not only registration, but includes follow-up, cross-

indexing for ready accessibility in a pathological file, and statistical surveys.

The mechanism adopted for registration of cancer cases begins in the medical audit department. Here, as diagnoses are punch-carded by mechanical tabulation, every chart with a diagnosis of neoplasm is sent to the central tumor registry for review. All of the malignant neoplasms are recorded as are certain benign tumors of special interest.

At registration, a large, visually prominent sticker is attached to the progress sheet of the record, and the chart is also stamped on its front cover to prevent future duplicate registration by medical audit. Follow-up begins automatically at the moment of registration, noting the next scheduled appointment of each patient in a "tickler" file. The "tickler" system is so arranged that the registry pulls the chart of every registered patient three days following his next anticipated visit and either abstracts the information recorded or goes into action if the patient has failed to appear.

Only one attempt at follow-up by mail is made, in which the patient is given a new appointment. If this fails field work begins, first by a public health nurse, and by a social service worker if transportation or domestic difficulties prevent return of the patient to the hospital. Immediate follow-up of this sort assures a pursuit of the floating fraction usually lost by more dilatory methods.

At times an inexperienced intern or a tired clinician will fail to indicate a return appointment for a cancer patient or may even close the case, in which event the registry reactivates the case and returns the patient to the department concerned. The registry also completes special two-page abstract forms recently developed by the state department of health for its own cancer registry.

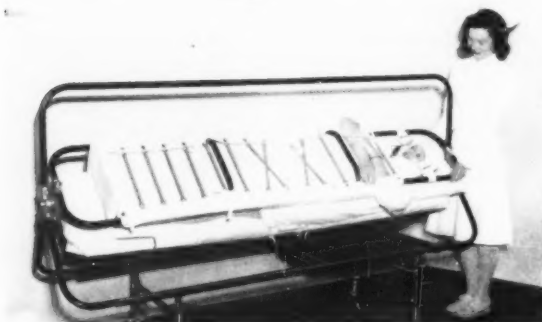
One such copy is sent to the state and one is retained in the central tumor registry, and cooperation between the two registries is of obvious advantage in follow-up. The registry is directed by the chief of clinical research who is also the radiation therapist for the hospital, with an assistant from the attending staff in tumor surgery.

Full-time personnel includes an executive secretary, three medical record librarians, a public health nurse, a social service worker and a record



## TURNING FRAMES

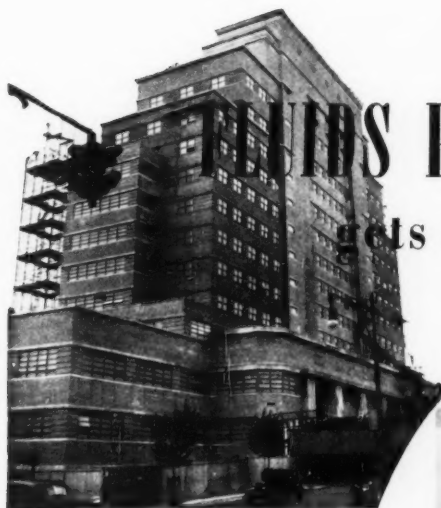
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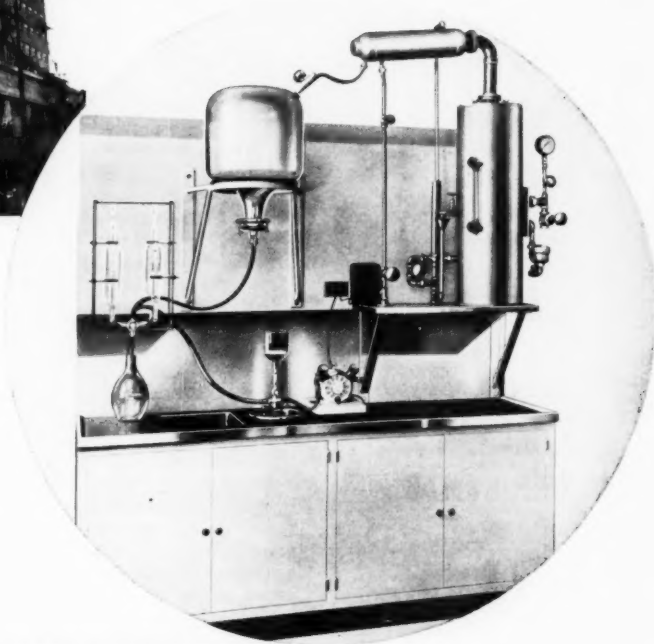
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clerk. The successful prosecution of this program will only become evident by 1952 and thereafter, when for the first time it will be possible to evaluate end results accurately, making available large series of cases for clinical research.

In education, the cancer service is mainly concerned with postgraduate instruction. Since January 1947, semi-annual two-day refresher courses have been conducted at the hospital under the aegis of the California Cancer Commission and with the support of the American Cancer Society.

An educational committee of the tumor board is responsible for the planning of programs, usually featured by a guest speaker with authoritative background. The content is directed toward fundamental considerations of recognition, accurate diagnosis, and effective treatment of major forms of cancer. Attendance for the last two courses exceeded 400, many of the registrants coming from widely separated areas in Southern California.

On the day preceding each refresher course, a day-long tumor pathology conference is conducted for pathologists as well as interested clinicians. This session has the same sponsorship and support as the refresher course, and is organized by the department of pathology of the hospital. In addition to these events, most of the staff of the cancer service contributes to the graduate training program in the hospital, and especially in general surgery. All of the resident surgical staff members rotate through the tumor surgical service during their training, and each year some members of the service conduct formal classes for these residents. Both medical schools have established cancer teaching projects which make full use of the clinical facilities of the cancer service and its staff.

The program in cancer research is still in a developing phase. A number of research projects have been in progress for several years, supported variously by the U.S. Public Health Service through the National Cancer Institute, the American Cancer Society, and one project with broad implications by the National Foundation for Infantile Paralysis. In common with all research in the hospital, correlation and support in applying for grants are achieved by the research committee of the medical staff, on which there is representation from the cancer service.

Further integration is obtained through the appointment of a full-

time research worker to the executive committee of the tumor board, and he is also secretary for this committee and for the research committee of the medical staff. All proposed research in cancer requires approval by these committees, and all publications based on hospital material, research or clinical, must be approved by the research committee.

With funds from the agencies already listed, as well as from the Board of Supervisors of the County of Los Angeles and early donations from private sources, significant progress is being made. An unused two-story building on the grounds of the hospital is now being converted into a cancer research institute, to which most of the present research projects will be moved. A mass spectrometer has been obtained, an isotope laboratory with a full-time, specially trained technician has been begun, and the full-time services of a physicist have been assured at the opening of the research institute.

A combined clinical and pathologic investigation of hormone therapy in treatment of metastases of breast cancer in bone is under way on the cancer service. A research project in cutaneous cancer by the department of dermatology offers considerable promise of significant results. The department of pathology is preparing material for a teaching collection with abstracts of history, treatment and end results, photographs, roentgenograms and microscopic sections. The photographic laboratory has been enlarged in its personnel and quarters, in part with the aid of funds from the cancer service.

This is a partial record of the slow evolution of a complete organization which began with the uncertainty and discontent of a few clinicians 26 years ago, one of whom is still the chairman of the tumor board. Although the original and continuing objective of this cancer service was to improve the clinical management of the cancer patient, a large general hospital can achieve a far broader program and contribute materially to cancer control on a regional rather than a local scale.

The successful prosecution of such a program requires a cooperative, continuous effort by individuals and departments alike to assure the greatest good for the greatest number, while furthering the search for more effective control of the ever menacing human problem that is cancer.



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\*Tuohy, E. B.: Practical concepts in anesthesia, Ohio State M. J., 43: 148 (Feb.) 1947.

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## Notes and Abstracts

Prepared by the Committee on Pharmacy and Therapeutics  
University of Illinois College of Medicine, Chicago 12

### THE ANTIBIOTIC OF CHOICE

SINCE the discovery of penicillin the development of new and effective antibiotics has proceeded at an almost geometric rate. While many of these agents possess selective therapeutic effects there is considerable overlap in their antibacterial activity. Organisms vary greatly in their susceptibility to any antibiotic, not only from one genus or species to another, but also from strain to strain within a given species. The widespread and indiscriminate use of antibiotics may result in drug resistant strains. Drug fastness has been produced in many situations in which maximal blood levels of the antibiotic have been achieved.

These factors, plus the increasing supply of new antibacterial agents may pose a problem as to the choice of antibiotic to be employed as a systemic chemotherapeutic agent. Cost, availability, potency, duration of action, stability, toxicity and ease of administration may be the deciding factors. By far the most logical approach to chemotherapy is to select the chemotherapeutic agent which is most effective against the organism and which produces minimal alterations, if any, in the physiology of the host. For the most part, selections are based primarily upon the susceptibility of the bacterial or viral agent. With these considerations in mind some of the salient features of antibiotic therapy, based upon clinically established facts, will be discussed.

#### PENICILLIN

The literature on penicillin is too massive to be reviewed in an abstract such as this. Only those facts will be outlined which are considered essential for adequate systemic chemotherapy with this agent.

**Chemical Properties.** Penicillin is an acid and is capable of forming salts

with certain basic compounds. It is relatively unstable and is decomposed rapidly by heat, especially in the presence of moisture. It is also decomposed by acids and alkalis. Salts of penicillin, such as sodium, potassium or calcium penicillinate, are more stable than free penicillin. Penicillin is said to be inactivated by certain heavy metals, such as mercury or copper, and is oxidized by such agents as hydrogen peroxide or potassium permanganate. Primary alcohols and aniline bases decrease the stability of penicillin.

**Dosage Forms vs. Blood Levels.** An aqueous solution of penicillin, given parenterally, is rapidly excreted in the urine, about 60 per cent being eliminated in one hour. In order to maintain a therapeutic level it is necessary to administer this form of penicillin at intervals of two or three hours. Tubular excretion is blocked by sodium benzoate, sodium hippurate and caronamide. The last is especially effective in maintaining a high blood level of penicillin for several hours following a single dose, or with continuous intravenous drip. These agents block the excretion of penicillin in the tubules purely by a mass effect. More prolonged blood levels of penicillin may be obtained by:

1. Incorporation of salts of penicillin in substances which retard absorption from an intramuscular site. A mixture of peanut oil and beeswax has been used most extensively. Difficulty in administration of this viscous substance plus the potential danger of sensitivity to the oil or beeswax has rendered this preparation relatively obsolete.

2. Formation of the relatively insoluble procaine salt of penicillin (procaine penicillin) to be administered in vegetable oil. This form provides an effective blood level for 24

hours following a single intramuscular injection of 300,000 units.

3. Incorporation of penicillin G in oil with aluminum monostearate, a water repellent, provides an effective blood level for 96 hours following a single intramuscular injection of 300,000 units.

Preparations of penicillin which afford a long duration of action also have a long latent period. It is therefore advisable to administer aqueous penicillin with the initial dose in order to establish a therapeutic dose rapidly.

Oral preparations of penicillin are available but are rather expensive owing to the necessity of giving about five times the parenteral dose in order to achieve the same blood level. This form, however, is least objectionable to the patient. It should not at present be substituted for parenteral penicillin in any acute infectious disease in which penicillin is indicated, but may be employed for several days after the acute process has subsided.

**Organism Resistance.** Many organisms are naturally resistant to penicillin; others which are normally susceptible may acquire resistance. Inadequate dosage and indiscriminate local usage are thought to facilitate organism resistance to penicillin. Those which normally resist the antibiotic effects of penicillin may do so by virtue of their ability to produce penicillinase. Those which acquire resistance do so by forming variants which appear in the form of mutations. This is a relatively slow process and in some species it does not occur at all.

**Reactions to Penicillin.** Penicillin per se is relatively innocuous but a variety of untoward reactions have been observed with penicillin therapy:

1. Convulsions due to direct irritation applied to the exposed brain or

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**DOSAGE:** 2 to 3 drops in each nostril 3 or 4 times daily.

1. Friedlaender & Friedlaender: Amer. Pract. 2:643 (June) 1948.

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### Bacterial Organisms Susceptible to Penicillin

	SENSITIVE	MODERATELY SENSITIVE
<b>GRAM-POSITIVE PATHOGENS</b>		
<i>Bacillus anthracis</i>	✓	
<i>B. subtilis</i>	✓	
<i>Clostridium botulinum</i>	✓	✓
<i>Cl. oedematiens</i>	✓	
<i>Cl. septicum</i>	✓	
<i>Cl. tetani</i> (tetanus bacillus)	✓	
<i>Cl. welchii</i> (gas bacillus)	✓	
<i>Corynebacterium diphtheriae</i> (Löffler's bacillus)	✓	
<i>Diplococcus pneumoniae</i> (pneumococcus)	✓	
<i>Staphylococcus elbus</i>	✓	
<i>Staph. aureus</i>	✓	
<i>Streptococcus a-hemolyticus</i>	✓	
<i>Str. faecalis</i>		✓✓
<i>Str. nonhemolyticus</i>		✓✓
<i>Str. pyogenes</i>	✓	✓
<i>Str. viridans</i>		✓
<b>GRAM-NEGATIVE PATHOGENS</b>		
<i>Hemophilus ducreyi</i>	✓	
<i>Neisseria catarrhalis</i>	✓	
<i>N. gonorrhoeae</i> (gonococcus)	✓	
<i>N. intracellularis</i> (meningococcus)	✓	
<b>SPIROCHETAL ORGANISMS</b>		
<i>Borrelia novyi</i>		✓✓✓
<i>Bor. recurrentis</i>		✓✓✓
<i>Leptospira icterohemorrhagiae</i>		✓✓✓
<i>Spirillum minus</i>		✓✓✓
<i>Treponema pallidum</i>	✓	

when administered intrathecally in doses above 25,000 units.

2. Allergic manifestations have been observed with prolonged and repeated use of penicillin therapy in about 10 per cent of the cases. These include urticaria, vesicular or exfoliative dermatitis, and various other types of skin rashes. Nausea and vomiting may also occur as an allergic response.

3. The Jarish-Herxheimer reaction (therapeutic shock) is the most serious of all reactions to penicillin. It may be one of the complications in the treatment of syphilis with penicillin and occurs only following injection of the initial dose, when it does occur. It is characterized by an exaggeration of all of the signs and symptoms of syphilis and is associated with fever. The mechanism is thought to involve a rapid destruction of a large number of spirochetes at one time with a liberation of their toxins. Such a reaction may be prevented by starting with smaller doses of penicillin (25,000 units) and gradually increasing the dose. It may be prevented also by first employing weaker spirocheticides such as potassium or sodium iodide.

### STREPTOMYCIN

Streptomycin is the active antibiotic principle produced by the mold, *Streptomyces griseus*. The drug is prepared as the hydrochloride or sulfate salt or

with calcium chloride as the complex double salt. Commercial preparations are relatively impure but are standardized on the basis of activity in terms of grams of the active streptomycin base. In the dry form, streptomycin is stable for one year if the temperature is maintained below 30° F. In solution, it will remain relatively active for one week at room temperature. Variation in the pH of the solution below four or above seven hastens the deterioration of the antibiotic. The drug should not be autoclaved. In general, only fresh solutions should be used parenterally to avoid the possibility of contamination.

**Mode of Administration.** Streptomycin is not absorbed from the gastrointestinal tract nor is it broken down significantly by intestinal enzymes. The optimal route of injection is intramuscularly in concentration of 100 to 200 mg./cc. of normal saline or distilled water. More dilute solutions should be used for subcutaneous injection. In severe infections, the intravenous route may be employed, using a 1 to 2 per cent solution in normal saline administered at a rate of 25 drops per minute. The drug may also be used topically on the skin and in the eye, and as an aerosol. Intrathecal injection is recommended by some but recent work demonstrating therapeutic levels of streptomycin in the cerebrospinal fluid

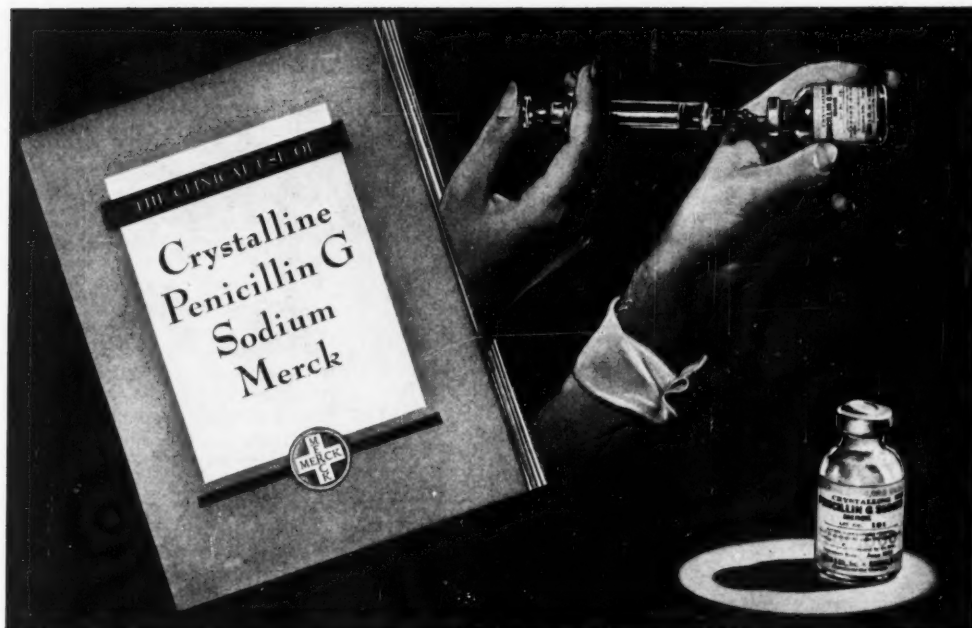
following intramuscular injection probably renders this route unnecessary.

**Dosage.** Total daily dosage is governed in large measure by the severity of the infection. In severe conditions, 2 to 4 grams per day can be given in divided doses every six hours. Less severe infections probably will respond to 1 to 2 grams per day. It is important to give adequate doses early in the course of therapy to avoid the development of resistance to the drug. Inadequate dosage predisposes to the development of such resistance.

Blood levels of streptomycin can be obtained by parenteral injection. It is not absorbed following inhalation or oral administration. A single intramuscular injection produces a maximum blood level within about three hours, following which there is a sharp decline. Multiple injections given three hours apart will maintain a constant or slowly rising blood level as long as such injections are maintained. Streptomycin is excreted primarily in the kidney in an unaltered condition. Approximately 70 per cent of a given dose will be excreted within 24 hours. The drug is also excreted to a lesser extent in the bile. Following parenteral administration the drug can be found in the peritoneal but not in the pleural cavity. In the presence of meningitis, the drug will pass the cerebrospinal barrier in therapeutic amounts.

**Bacterial Resistance.** One of the great disadvantages to streptomycin as an anti-infectious agent is the rapidity with which organisms become resistant to it. This is particularly a problem in the treatment of chronic infections, such as tuberculosis, although organism resistance has been known to develop within 24 hours in rapidly growing bacterial populations. If facilities are available, the sensitivity of the infecting organism should be determined at the outset of therapy. When this is known, the average doses cited should be disregarded and the dosage should be regulated to produce a concentration in the body two to four times that to which the organism is susceptible. Should a patient's condition deteriorate after once improving with streptomycin, organism susceptibility should again be determined and, if increased, the dosage should be increased accordingly or a new drug selected.

**Toxicity.** In administering streptomycin, the toxicity of the drug must



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be considered along with organism susceptibility. Toxic signs usually appear after high doses or prolonged courses of therapy. Probably the commonest toxic manifestation is that of vestibular damage leading to symptoms of tinnitus and vertigo. This disturbance is sometimes irreversible but patients are frequently able to compensate by means of visual and postural mechanisms. Skin eruptions and development of drug fever also constitute common toxic signs. Much less frequently, some impairment of hearing develops leading to permanent

deafness of varying degree. Other signs of streptomycin toxicity occasionally seen are proteinuria, hematuria, and signs of renal dysfunction, headache, arthralgia and lymphadenopathy. In individuals who habitually handle streptomycin, contact dermatitis may occur unless precautions are taken.

#### Organisms Susceptible to Streptomycin

Streptomycin is the drug of choice in infections caused by:  
Pseudomonas aeruginosa  
Pasteurella pestis

Mycobacterium tuberculosis  
Hemophilus ducreyi  
Klebsiella pneumoniae  
Streptococcus faecalis  
Streptobacillus moniliformis  
Organism of granuloma inguinale

It is effective but is not the best available agent in the treatment of diseases caused by alpha hemolytic streptococcus, Neisseria gonorrhoeae, Pasteurella tularensis, Hemophilus influenzae, Escherichia coli, Aerobacter aerogenes and Proteus vulgaris. Many of the organisms listed here are susceptible to other available antibiotics and by proper combination of agents many disagreeable problems of organism resistance and drug toxicity can be circumvented.

Shortly after the widespread success of streptomycin, a derivative of the drug was developed. Formed by the catalytic hydrogenation of the parent compound, it is known as dihydrostreptomycin. Early trials showed the new antibiotic to be as effective as streptomycin in many instances. Recent opinion, however, holds that because toxicity and organism resistance are as great a problem with dihydrostreptomycin, there is little reason to supplant streptomycin. Still another antibiotic, neomycin, has been extracted and is now in process of being evaluated.

#### AUREOMYCIN

Aureomycin is a golden yellow substance elaborated by a mold, Streptomyces aureofaciens, belonging to the genus of actinomycetes. This antibiotic was first described by Duggar, 1948. It is effective against a wide spectrum of both Gram-negative and Gram-positive organisms. It is also effective against rickettsiae and certain virus infections. Many penicillin and streptomycin-resistant organisms are sensitive to aureomycin.

**Properties.** The exact chemical constitution of aureomycin has not been well established. It is soluble in both acids and alkalis. At pH 2.5 a stable 4 per cent solution may be obtained as the hydrochloride. It is soluble as the sodium salt in a carbonate buffer solution at pH 8.5, but such a solution is unstable, losing 40 per cent of its activity in two hours. The activity of aureomycin is reduced by human serum. *In vitro* studies indicate that it loses activity rapidly at physiologic pH and temperatures.

**Fate in Body.** Aureomycin is readily absorbed by oral administration and appears in the urine within one



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hour. The maximal rate of renal excretion occurs between four and eight hours. In therapeutic doses it readily passes the blood-brain barrier. An oral dose of 1 gram affords a plasma level of 2 micrograms per cc. In dogs, following an intravenous injection of therapeutic doses, a plasma level of 40 micrograms per cc. was obtained for two hours.

**Bacterial Resistance.** Bacterial resistance does not readily develop to aureomycin. Sensitivity usually remains constant before, during and following prolonged aureomycin therapy.

Of a large variety of organisms tested, *Aerobacter aerogenes* was the only one to show only slight resistance following 30 transfers and the degree of resistance remained constant throughout 40 additional transfers. Many organisms which acquire resistance to penicillin and streptomycin are sensitive to aureomycin. In this respect it is of tremendous value as a complement to penicillin in prolonged therapy, such as in subacute bacterial endocarditis.

**Dosage.** For the treatment of acute infections the recommended oral dose

is 5 to 10 mgm./kg. every four hours. For mild infections, 5 mgm. per kg. of body weight orally are thought to be sufficient. Owing to the instability of an alkaline solution and irritation of the stable acid solution, parenteral administration is not recommended. On a weight basis aureomycin is less effective than penicillin but compares favorably with streptomycin against most Gram-negative bacilli. For topical application in staphylococcal, pneumococcal and influenza conjunctivitis the borate salt as a 0.5 to 1.0 per cent solution is well tolerated by direct instillation into the conjunctival sac, one or two drops every two hours.

**Toxicity.** Aureomycin is relatively nontoxic. Following oral administration nausea and vomiting and slight diarrhea have been noted in some cases. An abrupt rise in body temperature may be noted following oral medication in brucellosis. This may be associated with mild symptoms of shock and develops, if at all, about eight to 12 hours following the initial dose. Allergic responses have not been reported but it is felt that aureomycin is potentially allergenic.

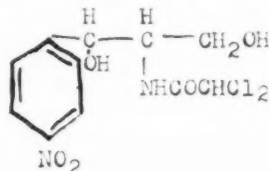
#### Organisms Susceptible to Aureomycin

*Brucella melitensis*  
*Rickettsia* of Rocky Mountain Spotted Fever  
*Rickettsia* of Q. Fever  
*Rickettsia* of rickettsialpox  
*Virus* of lymphopathia venereum  
*Virus* of psittacosis  
*Virus* of primary atypical pneumonia  
*Pneumococci*  
*Str. hemolyticus*  
*Meningococcus*  
*Gonococcus*  
*Bacterium tularensis*  
*Organisms* of the *Coli-aerogenes* group  
*E. typhi* group  
*Friedlander's bacillus*  
*Salmonella*

Aureomycin has shown promise against the spirochete of relapsing fever and against *hemophilus pertussis*.

#### CHLORAMPHENICOL

Chloramphenicol (chloromycetin) is the active antibiotic principle present in the filtrate of the mold, *Streptomyces venezuelae*. It is a relatively simple aromatic compound with the following structure:



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synthetic and natural products, both of which are being studied with regard to potency and toxicity.

**Dosage and Route of Administration.** Chloramphenicol has been used intravenously and orally but at present the oral route is preferred. The drug is available only in 250 mg. capsules. The dose administered is dependent upon the weight of the patient and the severity of the illness. In either a moderate illness or a severe illness a priming dose of 60 mg./kg. is recommended. The patient should then be maintained on 30

to 60 mg./kg. per day or 60 to 120 mg./kg. per day depending upon the severity. The drug should be given around the clock in six divided doses. This regime is applicable to both children and adults. Duration of the therapy will vary with the disease and the response of the patient.

**Fate in Body.** The drug is rapidly absorbed from the gastrointestinal tract. Administration of an initial dose of 2 grams followed by  $\frac{1}{2}$  gram eight hours later was shown by Ley and his co-workers to produce in a normal subject a blood level of more

than 10 micrograms per cc. at two hours and above 5 micrograms per cc. at eight hours. The drug is broken down in the body to the extent of about 90 per cent. The breakdown products and a small percentage of active drug are excreted in the urine. Therapeutic concentrations of chloramphenicol can be reached in the urine with the above dosage.

**Organism Resistance.** A tendency for the development of resistant organisms has been shown *in vitro* in the presence of inadequate concentrations. Although this has not been reported in the clinical trials, therapy should still be conducted vigorously in the interest of rapid and complete cures.

**Toxicity.** Chloramphenicol is relatively nontoxic. At present the only complications of therapy have been nausea, vomiting and looseness of the stools which may interfere with vitamin absorption. The incidence of toxic signs appears greater in ambulatory patients than in patients at bed rest.

#### Organisms Susceptible to Chloramphenicol

On the basis of limited clinical trials the drug has been shown to be effective in diseases caused by the following organisms:

Rickettsia—all varieties  
Escherichia coli  
Aerobacter aerogenes  
Proteus vulgaris  
Pseudomonas aeruginosa  
Brucella  
Eberthella typhosa

In addition, chloramphenicol has been shown to be effective *in vitro* against the following pathogens:

Viruses of the lymphogranuloma—pittacosis group  
Bacillus anthracis  
Corynebacterium diphtheriae  
Diplococcus pneumoniae  
Hemophilus pertussis  
Klebsiella pneumoniae  
Neisseria meningitidis  
Neisseria gonorrhoeae  
Pasteurella pestis  
Salmonella enteritidis  
S. paratyphi  
S. schottmülleri  
S. paratyphi  
Shigella dysenteriae  
Sh. paradysenteriae  
Sh. sonnei  
Streptococcus hemolyticus  
Str. nonhemolyticus  
Vibrio comma  
Nocardia asteroides  
Actinomyces bovis

Although clinical trials to date have been very encouraging, it is still too early fully to evaluate the effectiveness or toxicity of this new antibiotic.—T. R. SHERROD and DANIEL LANG.

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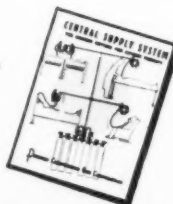


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# Food and Food Service

Conducted by Mary P. Huddleson

## THE SELECTIVE MENU IS A SUCCESS

*in the small community hospital, too*

THE selective menu is not a new idea and a great deal has already been written about it. The only reason for adding to the literature on the subject is to show how a small hospital can have a selective menu while working with a minimum number of employees and a modest food budget.

For several years we had wanted to have selective menus, but the limited number of employees and their inexperience had made us hesitate. Finally we decided to try a selective menu for lunch only, since that was when the most people were on duty. The results were successful beyond our wildest hopes. The patients and doctors were enthusiastic. The nursing department liked the idea. The tray girls thought it easier and from their standpoint an improvement over our former system of marking beverage and other preferences on the tray card. Hence a new idea was put into operation—and not a single objection arose or prejudice had to be overcome! It was unbelievable but true.

### EVERYBODY IS HAPPY

Remarks like these are almost daily occurrences. "Oh, the food is very good. I choose my own you know." "I can have anything I want." "I like choosing my own food." "I dislike wasting food. Now I can order just what I want." Meanwhile the doctors commented, "That's a good idea; why didn't you do it long ago?" "My patients certainly like your new selective menus."

The system went so smoothly and patient and employee satisfaction was so great, we immediately made plans to use the selective menu for all three meals.

Our system involves a minimum of work. Each morning when the nurse's aide brings the nourishment slip to the kitchen, she picks up the menus

for the next day. The head nurse supervises the checking of the menus which are returned to the kitchen by 1 p.m. The aide in the dietitian's office then tallies the items and gives the figures to the dietitian. For our 100 bed hospital this requires about 30 minutes, and any clerk or tray girl can easily learn to do it accurately if there is not an aide or clerk in the dietitian's office. These tallied figures then serve as the basis on which the dietitian makes the kitchen work sheet. It involves no extra work on her part.

A large selection would, of course, increase the costs. The greater the variety, the more labor is required. It also requires a more varied inventory, which would increase food costs, and there would be more leftovers since it is impossible to prepare everything to the exact amount that will be used. Fortunately, a large selection is not necessary. It has been our experience that too large a choice is confusing to the sick person. A limited choice satisfies his desire to select his own food without placing him under a mental strain. A variety from day to day is highly desirable, however, and is easily obtained when the daily choice is limited.

To keep the work simple, we use the same menu in the personnel pay cafeteria. This, however, is adjustable and serves as an outlet for any leftovers. On the other hand, if the census suddenly changes and we are running short on some food, it can be taken from the cafeteria and a substitution can be made there. We have found the choice entirely satisfactory in the cafeteria, as well as with the patients.

In the hope that it may help someone else, we present the menu outline which we have found very satisfactory. It has not increased either our labor or our food costs.

### Breakfast

*Fruit*  
*Fruit juice (frozen or canned)*  
*(No preparation necessary)*  
*Dry cereal*  
*Cooked cereal*  
*Egg*  
*White toast*  
*Whole wheat toast*

### Lunch

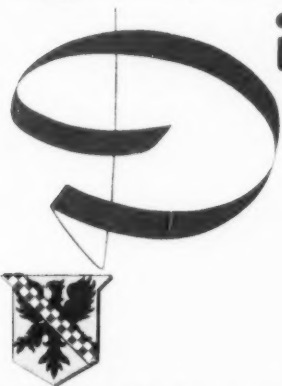
*Soup*  
*Entrée*  
*Sandwich*  
*Salad*  
*Made dessert (pudding, cake, cookies)*  
*Fruit (fresh or canned. No preparation necessary)*

### Dinner

*Meat (with a choice of fish on Friday)*  
*Potato*  
*Vegetable*  
*Salad*  
*Made Dessert*

The variety of dry cereal and of cooked cereal changes daily. The eggs are prepared a different way each day. About twice a week bacon is served in place of egg. A sweet bread or roll, which is purchased, is offered about twice a week. Since we must prepare eggs for the soft diets, it is just as easy to prepare more and offer them as a choice when we have the sweet bread or roll.

When ice cream is the dessert we offer a choice of vanilla, which we

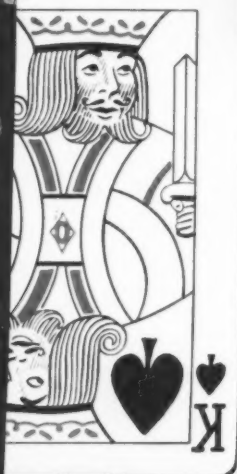
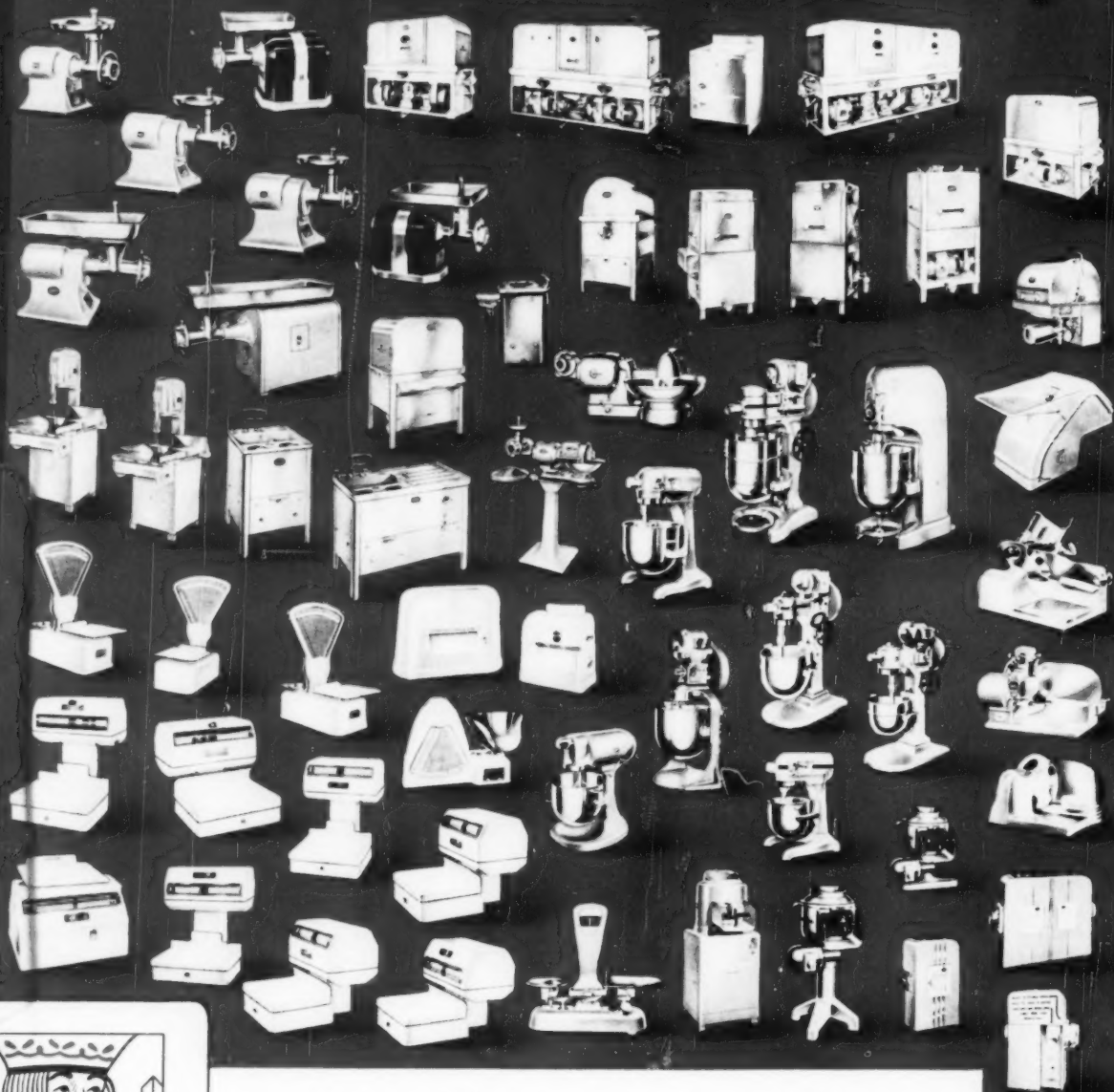


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must keep for the soft and liquid diets, and one other variety. We have found this selection satisfactory, although fruit, gelatin or custard could easily be given as a choice with little or no extra preparation. It has been our experience that simple desserts are favorites and are often chosen in preference to more complicated and expensive desserts.

There is always the choice of white or whole wheat bread. The choice of beverages at breakfast includes coffee, tea, cocoa, coffee-substitute or milk. The choice for lunch and dinner is coffee, tea, milk or buttermilk. These are the beverages which we learned from experience were in demand by our patients.

We are frequently asked, "Has the selective menu reduced your food cost?" According to our food cost figures we have not been able to show any saving. We do feel, however, there must be a slight saving. On the maternity ward this is especially true.

Because we always received complaints about these women being hungry, we sent large amounts of food on all the maternity trays. With the selective menu we have learned that while the nursing mothers do consume large amounts of food, our numerous non-nursing mothers eat much less. Some, in fact, are the smallest eaters in the house.

We find that patients usually eat what they check. Furthermore, they do not check everything on the menu just because they feel "they have it coming to them."

There has been no change in our labor cost.

The big factor in selective menu, however, is not food or labor cost, but patient satisfaction. Like everyone else who has used the system, we find it highly satisfactory. We feel we are getting a tremendous amount of good will at no extra cost. Beside the usual satisfaction the patients receive from selecting their own meals,

we find the selective menu creates confidence in the hospital. When patients find they can choose their own food "just like in the big city hospitals," to them it is a tangible proof that the hospital is maintaining high standards and giving them every care they would get in the larger cities. It impresses the patient favorably, creating confidence and good will toward the hospital. It is an excellent means of furthering public relations.

We recently had a new superintendent of nurses join our staff. When she had been here a few days she said, "I have just come from the maternity ward. The women were so busy checking your menus and having such fun about it." So when the food becomes fun, and the cost is no more, it is well worth a try. The selective menu is just as workable in the small community hospital as in the larger hospital and can be adapted with very little difficulty to any but the most meager budget.

## NOTES ON EFFECTIVE FOOD BUYING

### HENRY A. LARSON

Business Manager  
Healthwin Hospital  
South Bend, Ind.

ONE source of constant worry to hospital administrators in this period of rising costs of operation is food expenditures. It is here that the story of rising expenses is most dramatically demonstrated. This is true because the changes are seen every day. The province of food buying is also one of the most neglected. For this reason, I believe that the person in charge of purchasing can ease the impact of higher costs by using proper methods of buying.

The first step in the purchase of food is the preparation of adequate specifications. One day while visiting a large wholesale house in Chicago I was shown a letter from a hospital in Wisconsin. The writer wanted a quotation on "six cases of corn." The manager of the wholesale house said he was ignoring the request as he could submit 23 prices and still be within the limits requested by the hospital. He stated further than many hospitals operated at about 50 per cent efficiency when buying food. Is it any

wonder that we need to improve our methods of food buying?

There are five major facts which must be brought out by the specifications. These facts are: (1) size of container and number of containers per case; (2) grade desired; (3) variety desired; (4) geographic location desired, and (5) size or count. Here is a sample of a specification that meets these requirements:

*"No. 10 cans APRICOTS—Choice California Santa Clara Blenheims, 85-96 unpeeled halves in 40 per cent syrup. They are to be packed 6 cans per case."*

This specification protects both the hospital and the vendor. It sets a standard which is a minimum. Any merchandise so ordered can be returned if it does not measure up to the requirements. If requests for prices meets such standards, vendors will be more anxious to quote on your needs

because they are given equal opportunity and will not be undercut by a bid on some item that is substandard.

Last, but by no means least, it allows the dietitian to plan her meals according to the quantity specified. For example, in the specification quoted she can count on a minimum of 85 unpeeled halves. She can thus determine how many cans must be opened to provide a meal and can also figure accurately the cost of the serving per meal.

One of the major points in preparing specifications that should be followed carefully is the grade specified. Under present accepted gradings one not only specifies quality, he also specifies sirup content. Grades are as follows:

1. Standard—both fruits and vegetables. Fruit must have 25 per cent sirup. This is the minimum grade.
2. Extra standard—vegetables.
3. Choice—fruits in 40 per cent sirup.
4. Fancy—both fruits and vege-

tables. Fruit must have 55 per cent sirup. This is the highest grade.

5. Pie grades—fruits used for pies and baking. They have no sirup.

Under present laws the sirup content is guaranteed and so the buyer need not spend so much time on that question.

Variety of the item desired is important to the buyer. An illustration can be found in peas. One may prefer Early June peas to sweet peas. Yet, if they are not specified, the vendor will usually bid on the item that will reflect to his advantage. The same is

true in the selection of corn, two varieties of corn being Golden Bantam and Country Gentleman.

Geographic location is helpful in obtaining the best product for the price as products raised in certain locations excel the same item grown elsewhere. Indiana and California tomatoes are considered to be the best in the country. Wisconsin peas are accorded top position by many, and so on down the line.

Finally, for obvious reasons, one must specify the proper size of container and how many cans per case.

Many of the major wholesale houses quote on price per dozen cans while other vendors quote per case price. It can make a difference in selection that would result in selecting the most expensive item if container size and case content are not set forth in the specifications.

There are other minor points that reflect the completeness of the specification and should be kept in mind when buying food. These points are:

1. Style, which refers to the makeup of the item. An example is seen in corn. There is cream style, whole, and corn on the cob.

2. Quantity actually needed.

3. Quality, to determine items that best meet the needs of the hospital. This should include desires and tastes of the patients.

When all of these factors have been taken into consideration by the person preparing the specifications the purchase of food will show improvement. The person responsible for the preparation of food specifications will find the following aids available and valuable:

1. Government specifications for the grading of fruits and vegetables. Marketing Service, U.S. Department of Agriculture.

2. Specifications of California canned fruit. California Cannery League, San Francisco.

3. Canned Goods Specifications and Buying Procedures. A. Froorman. Printed in February 1942 issue of the *American Restaurant* magazine.

4. Manual of Specifications for Canned Fruits and Vegetables, American Hospital Association, Chicago.

5. Effective Food Buying. A. Froorman, Chicago.

If these materials are used, the purchasing agent should be able to make a definite stand against the onrushing pressure of increasing food costs. This will be accomplished by increasing the effectiveness of the purchasing procedures up to and possibly higher than the 50 per cent level of efficiency. If the hospital purchasing agent is genuinely interested in doing a better job, he will find many willing helpers from the industry. They, too, are interested as it usually means more opportunity for them to increase their volume of business.

In closing, it is well to remember that effective steps in the preparation of specifications and planning food purchases make your job easier and result in better service.

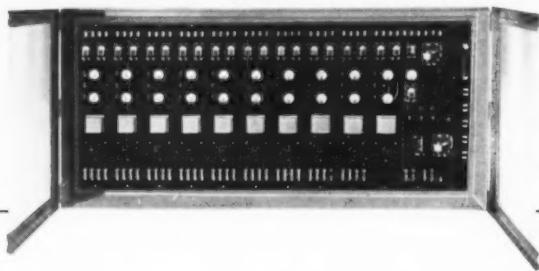


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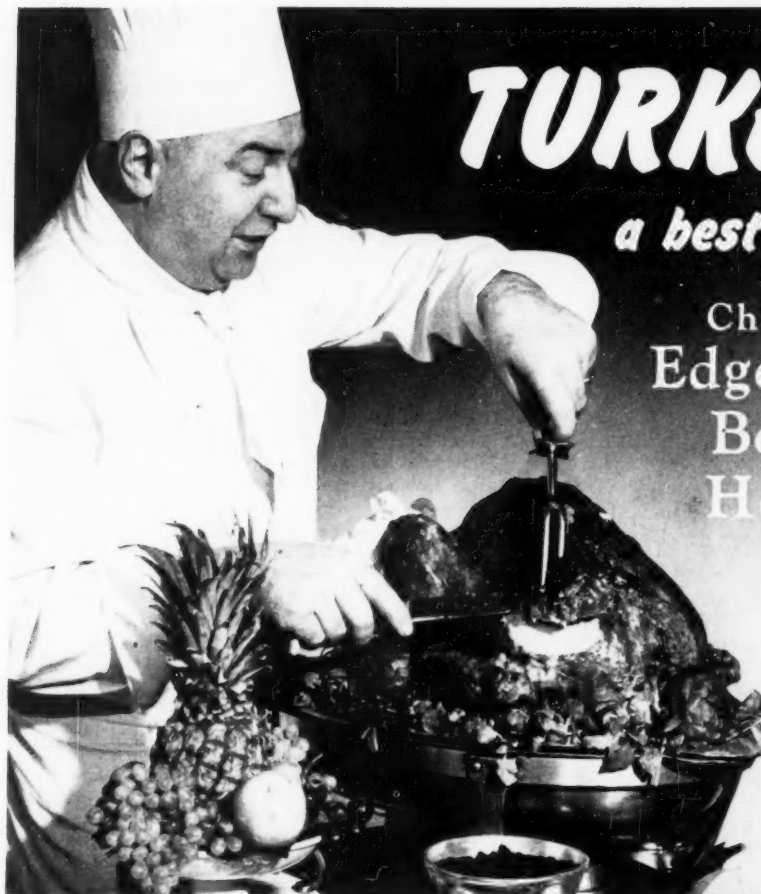
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# TURKEY-

*a best seller*

at  
Chicago's  
Edgewater  
Beach  
Hotel

Left—Chef Peter Ungarette

Below—Catering Manager  
Walter F. Schrott, who  
says: "Turkey is a con-  
sistent best seller in our  
swank Marine dining room  
and moderately priced  
Colonnade. And we do our  
best to promote interest  
in turkey because the low  
cost-per-serving is defi-  
nitely profitable to us."

With turkey more plentiful than at any time since 1945 — and back on the bargain table in price — food purveyors are reporting greatly increased sales of turkey dishes. From the lowly sandwich at lunch counter or drive-in to the full course turkey dinner at the swank hotel dining room, turkey is king this year.



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## HIGHLIGHTS OF THE A.D.A. CONVENTION

IN THE "mile-high" city of Denver, briskly alert to the present and proud of its traditions of the past, more than 1700 members of the American Dietetic Association gathered at the 32nd annual meeting October 10-14. They came to observe, to learn, to discuss common problems, to accept almost unanimously a drastically revised constitution.

Somewhat revolutionary ideas on the problem of dietary management of obesity and diabetes were presented at the first evening session. Dr. Harry J. Deuel, dean of the graduate school of the University of Southern California, stated that "there is no proof that high fat diets are a predisposing cause of obesity." The high satiety value of fats, which remain in the stomach for a prolonged period, actually prevent excessive caloric consumption, he said. Under certain conditions fats also exhibit a protein-sparing action that is not demonstrated by carbohydrates and have a like effect on some B vitamins, especially thiamin.

### PSYCHIATRIC PROBLEMS

Dr. Franklin G. Ebaugh approached the problem from the standpoint of the psychiatrist. Significant psychological problems arise when a patient is required to restrict, expand or regulate food intake, he declared. Too often the patient is treated as an ulcer, a hypo-active pancreas, or merely as a carrier of superfluous adipose tissue. The work of the dietitian will become more effective as she increases her understanding of the patient as a person and "the number of impossible problem patients will strangely decrease."

Dr. Eaton M. MacKay of the Scripps Metabolic Clinic, La Jolla, Calif., sounded a note of warning in the care of the diabetic and the current tendency to liberalize the diet with the aid of generous amounts of insulin. Dr. Mary B. Olney of the University of California Medical School closed the discussions with a description of a children's diabetic camp which serves

### MARY P. HUDDLESON

to demonstrate to the child that his problem "is not purely personal and is not a physical or mental handicap."

Wednesday's meetings covered a wide range of topics, from public relations, vocational guidance, care of the premature infant, instruction of student nurses, history of nutrition and dietetics, dietetic advisory service to institutions and applied nutrition, to the ever-present problem of food administration. Penelope Easton, dietary consultant for the Alaska Department of Health, discussed the basic local foods, such as reindeer and seal, and the native greens and berries. Mrs. Mariana Kulas of the Colorado Experiment Station described her work at the altitude chamber there, where the problems of food preparation at high altitudes are investigated.

Jane Hartman, consultant dietitian for the Maryland State Health Department, said that many qualified dietitians had been placed in the food service departments of institutions there as the result of her work which is primarily concerned with raising the standards of food service in all state institutions. Mildred A. Baker, Pennsylvania State College, described the new million-dollar college food service department, semicentralized, concerned with all purchasing, meat fabrication, and baking sufficient to serve 15,000 meals a day. Experimental work is conducted in a kitchen equipped for quantity cookery.

Dr. Helen T. Parsons of the University of Wisconsin urged that all dietitians develop an active interest in nutrition research even though they may not appear in the specialized rôle of "research dietitian." Dr. Robert W. Keeton, head of the department of medicine of the University of Illinois, discussed the influence of distribution of meals on appetite and hunger drive in the sick. He said that man and experimental animals may be educated to eat greatly in-

creased quantities of food when meals are limited to two a day and, on the other hand, that total intake can be reduced by frequent feedings. The primitive hunger drive, uninhibited, leads to obesity, but if this hunger drive "is lost by the integration of inhibitory reflexes" appetite disappears with resultant anorexia and nausea.

Food service equipment, sanitary maintenance, food production and service were the topics that predominated at the Thursday sessions. Interestingly enough, all speakers were representative of the commercial field. George Kanberg of United Air Lines urged that there be "competitive food production in the hospital" comparable to that essential to successful food production in the commercial field.

Two dietitians aid Mr. Kanberg in the production of 3,500,000 "sky meals" prepared in 13 flight kitchens. He urged the use of the casserole type of service in the hospital and stressed the need of so assembling operations that the job is "brought to the worker." He referred to a training film for workers now available through the Chicago office of his organization.

### HOW TO PLACE EQUIPMENT

Mozelle Craddock, food service director and dietitian of the Hamphill Wells store in Lubbock, Tex., speaking on the placement of equipment, urged careful study of a preliminary plan for placing equipment, with the processes of cleaning, preparing and cooking flowing through efficiently to the final point of service. This plan should be checked and rechecked to avoid waste motion and unnecessary equipment. Fred Schmid of the Rexall Drug Company said that the profit factor should be kept in mind in the institutional as well as in the commercial field. Only carefully planned and improved facilities can match increasing labor costs, thus permitting the necessary profit.

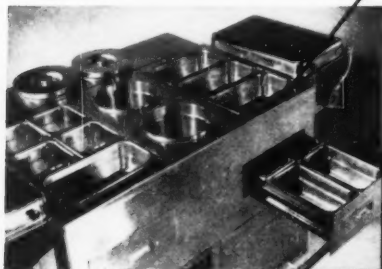
John T. Lynch, Consolidated Grocers' Corporation, in a dynamic discussion of work simplification and job

## one food conveyor gives you dozens of inset arrangements for your selective menus

*T*his new electrically-heated food conveyor is designed specifically for selective menus. It will contribute to successful diet-therapy in your hospital. Eighteen insets in various sizes can be placed in the wells in different combinations. These provide innumerable top deck arrangements to meet the requirements of any given meal. In addition to the two rectangular wells, there are two round wells for soup and broth and two heated drawers for special diets and rolls. The entire unit is made of heavy-gauge corrosion-resistant stainless steel. Top and body are of seamless, crevice-free construction, meeting the strictest hospital standards for sanitation and durability. If you're contemplating the "selective menu" idea, write for information about Model ALS-4922.



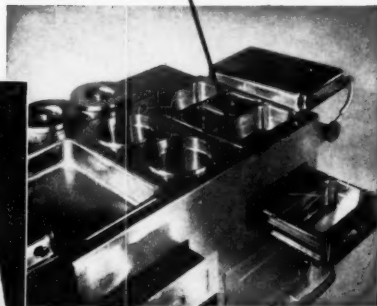
▲ EIGHTEEN square and rectangular stainless steel insets in various sizes can be arranged in many combinations.



Above: Today's menu may call for four square and four rectangular insets as shown here



Right: While tomorrow, square and rectangular insets may be arranged like this.



▲ Above: Still another arrangement is shown. Note the heated drawers and the convenient serving shelf.

**NEW BLICKMAN SANITARY TOP**

**ELIMINATES CREVICES**

**BLICKMAN CONSTRUCTION**  
Round and rectangular wells are integral part of top — forming continuous, crevice-free surfaces.

**ORDINARY CONSTRUCTION**  
Wells are separate units attached to top—permitting crevices to form where edges meet the top deck.

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explaining merits of the "Selective Menu" and describing this and other Blickman Food Conveyors.



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**S. BLICKMAN, INC., 1512 GREGORY AVENUE, WEEHAWKEN, N. J.**

analysis, epitomized the need for a fresh point of view in the tradition bound operation of some hospitals when he said, "Observe the turtle, he maketh progress when his neck is out."

Interest in the dietitian's biggest job, mass feeding of people, carried over to Friday, when Marion D. Floyd, chief dietitian of Massachusetts General Hospital and chairman of the association's food administration section, presided at a panel of experts on the scheduling of employes in which dietitians distinguished in the hospital field held the spotlight. Margaret Gillam of the American Hospital Association urged that scheduling start with the work loads of the chief dietitian and her assistants before attention is given to the subsidiary employes. It is comparatively easy to work out a system whereby each dietitian on the staff is interchangeable. It is difficult to train lay assistants to take over some of the work loads of the professional staff.

#### MAY NOT BE GOOD SUPERVISOR

Clara Childress, chief of the education section of the dietetic division, Veterans Administration, Washington, D.C., pointed out what these "lay assistants" can do. A "good worker" is not necessarily a potentially good supervisor. Job analyses will show up inefficiencies and misdirected effort.

Edith Ferguson, Alameda County Hospital, Oakland, Calif., warned against schedules that are static and job descriptions that are too rigid in institutions where unexpected demands are a daily occurrence. Alberta Hughes, Kennedy Veterans Administration Hospital, Memphis, Tenn., listed some of the jobs for which "lay food supervisors" may be responsible: tray and cafeteria services; instructing and scheduling new employes; maintaining and keeping equipment in repair; and keeping dish records up to date. A hopeful note was struck by Kathryn Heitshu, Medical College of Virginia, Richmond, who has been assisting in working out a training program for high school boys and girls that will fit them for hospital food service responsibilities. A year's training in school and six months in the hospital grounds them in the principles of sanitation and personal hygiene and good food standards.

Jack Martin, director of the school of hotel and restaurant management at Denver University, asserted that

pay does not rank first in the employee's sense of satisfaction in his job—it is seventh or eighth. He said a job description should comprise: (1) who does it; (2) when it is done; (3) how it is done, and (4) why it is done. Hannah Hotvedt, General Rose Memorial Hospital, Denver, said that in applying the technics of scheduling employes one should first know the standard of man hours per unit of production. She gave the figure of 250 to 300 man hours per thousand units, and said the man hours required increased as much as 20 per cent during a period of marked employe turnover—hence the need for careful selection and subsequent employe satisfaction on the job.

Mr. Martin said that from the job description—the duties and responsibilities involved—we obtain a series of specifications, or certain factors, which when measured up aid in determining salary scales. He suggested that five factors (mentality required, manipulative skill, responsibility on the job, physical requirements of the job, and working conditions in general) requisite to a job might be assessed by a point system which could serve to determine proper salary scales for food workers. A committee made up of management, labor and an impartial umpire might also aid in the matter of inequities in pay.

Focal points of interest at the closing day's sessions also concerned dental health and recent advances in nutrition. Dr. Guttorm Toverud of the Dental School, Oslo, Norway, startled his audience with a report of studies of dental caries among Norwegian children. Caries decreased consistently during the war years, probably owing to the lowered consumption of refined carbohydrates and increased consumption of "natural" foods. Greater amounts of the protective foods were included when all food was rationed in Norway during the war. Supplementing this theory, Dr. Paul H. Phillips, professor of biochemistry at the University of Wisconsin, said that

high fat diets, high protein diets, milk, and low sugar diets tend to reduce the incidence of dental caries.

Fresh cabbage juice, nuclear energy, and vitamin B<sub>12</sub> in applied dietetics also received attention. Dr. Garnett Cheney, Stanford University Hospital, detailed the use of the first in the experimental treatment of peptic ulcer and referred to an unidentified antipeptic ulcer factor, vitamin U. Untold benefits from the application of nuclear energy were suggested by Dr. Bernard Roswit of the Veterans Administration Hospital, New York City. Radio-isotopes trace the biological progress of wandering fats, proteins, vitamins and so on through the body, and eventually, it is hoped, will aid in the discovery of the cause and the cure of cancer. These radio-active isotopes may also unlock the secrets of the transformation of the sun's energy into man's food, thus revitalizing agricultural methods.

#### TWO AWARDS PRESENTED

The final session, the annual banquet, was dramatized by the presentation of two awards; by the speaker, Dr. Lillian Gilbreth, heroine of "Cheaper by the Dozen"; by the gracious presiding officer, Helen E. Walsh, president of the association, and by the introduction of new officers.

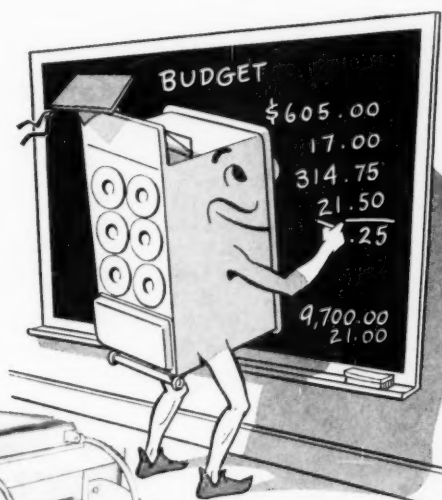
These include: President, Elizabeth Perry, City Hospital, Cleveland; president-elect, Dr. Lillian Storms Coover, consultant, Gerber Products Company; secretary, Dr. Margaret A. Ohlson, head, foods and nutrition department, Michigan State College, East Lansing; treasurer, Mrs. Winifred Howard Erickson, Ancker Hospital, St. Paul. Section chairmen for the coming year are: Marion Floyd, Dr. Gladys Kinsman Lewis, Marguerite L. Petree, and Dr. Ercel S. Eppright.

The annual Marjorie Hulsizer Copher award was granted to Fairfax Proudfit.

Pearl Jackson, graduate student at Iowa State College, was awarded the first annual Mary Swartz Rose fellowship of \$1000 established by the Nutrition Foundation, Inc., for graduate study and research in nutrition and allied fields. Miss Jackson, who took her dietetic internship at Johns Hopkins Hospital under Phyllis Rowe, will complete her doctorate and then direct the operation of a test kitchen at Michigan State College, which she had already established in the women's residence halls.



# HOW A FOOD CONVEYOR CAN HELP YOU FIGURE A BUDGET



## They are Patented

The many valuable advantages of Ideal special design and construction cannot be found in any other unit. These priceless results of Ideal research, study and long experience are fully protected by patents in the United States, Canada and overseas countries.



The efficiency, performance, convenience and rugged durability of Ideal Food Conveyors are so outstanding that the money saving economy in operation often is overlooked. The facts are that it costs only 5/100 of one cent per meal per patient when the hot, fresh, appetizing food is served from an Ideal unit. Here are the figures based on actual operating tests:

The Ideal Conveyor uses 961 watts—actually less power than is required for the average roaster, heater, iron and other small appliance. The average preheating requires 1 1/2 hours. The total current needed is 1.44 K.W. Using 2 cents per K.W. as the rate (higher than the average), the cost of current is

.0288 cents. Dividing this by 60 meals, the capacity of Ideal Model 1431, the cost per patient is seen to be less than five one-hundredths of one-cent!

Rigid top deck, patented bridge type assembly of food wells and heating elements, all-welded body construction, rugged, readily replaceable bumper, specially designed wheels, oversize rubber tires, and many other exclusive and patented features are combined in an Ideal with an operating cost almost unbelievably low. Many Models enable you to choose one to meet your service and budget requirements. Write for catalog and specification data.

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ESTABLISHED 1884

Distributed by The Colson Corporation, Elvira, Ohio : The Colson Equipment and Supply Company, Los Angeles and San Francisco. In Canada: Canadian Fairbanks-Morse Company.

*Ideal*  
**FOOD CONVEYOR SYSTEM**  
*Found in Foremost Hospitals*

## FOOD FOR THOUGHT

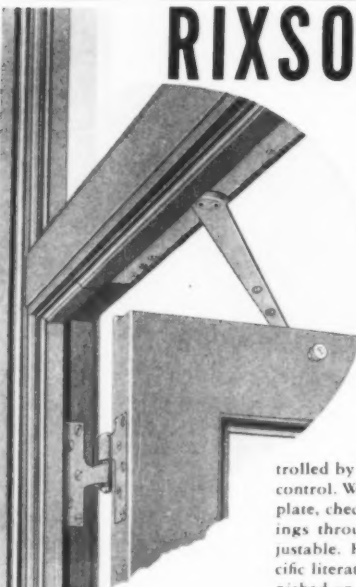
### Small but Thrifty

Small and medium-size eggs often are the thriftiest buy at this time of year, marketing specialists of the U.S. Department of Agriculture advise family food shoppers. Because of the seasonal abundance these small eggs usually sell for less than large eggs—so much less, in fact, that they are a better buy.

The difference in price per dozen between large and small Grade A eggs may be from 15 to 20 cents. Even medium-size eggs may represent quite a saving—10 cents or more—over large eggs. It pays, therefore, to check size as well as quality in relation to price in order to get the most for your money.

To be sure, a small shell does not

hold as much egg as a large one, but it may offer all that many people want in one serving. A small egg, simply because of its size, may even look more appetizing to some. Small hard cooked or stuffed eggs are attractive in salads or lunch boxes. Two small fried or poached eggs on the breakfast plate may have more appetite appeal than one large egg.



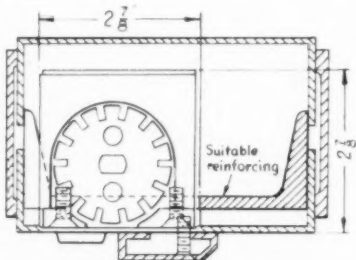
# Rixson

## CONCEALED OVERHEAD DOOR CHECKS

**Especially Compact for NARROW Headframes and Transom Bars**

**... Metal or Wood**

Rixson No. 220 concealed single-acting overhead door checks—for interior, vestibule or entrance doors—are particularly desirable when small space is a factor. These sturdy, reliable units are only 2 7/8" wide x 2 7/8" high and 17" long. Checking action is controlled by two valves—for closing and latch control. When door is closed, no parts of the plate, check or arm are visible. Roller bearings throughout. Spring control easily adjustable. Hold-open feature available. Specific literature and specifications will be furnished on request.



Special problems of installation will receive prompt attention from the Rixson engineering and design departments.

### The Oscar C. Rixson Company

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Established 1900

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### Meat on City Tables

Twenty-four cents out of every dollar city families spend for food goes for meat. An additional six cents goes for fish and poultry. Food itself takes about one-third of the family's weekly income.

These are some of the findings from a U.S. Department of Agriculture survey of how city families eat, made in the spring of 1948. The Bureau of Human Nutrition and Home Economics conducted the study in 68 cities.

City homemakers buy more beef than any other meat, and pork is a close second, the survey revealed.

Bacon is more widely used than any other single meat item. Families with low incomes use bacon just about as much as families with high incomes, although it is a comparatively expensive meat.

Ground beef is the most popular beef product used by the families surveyed. But income affects the amount families use. As income rises up to \$4000 a year, families use more ground beef while over-\$4000 families use less.

As expected, families with higher incomes buy more beef steak and roasts than low-income families. Over-\$4000 families use twice as much of these expensive cuts as do families with incomes under \$1000.

Next to beef and pork, poultry—mainly chicken—is used most widely. Bologna, frankfurters and other lunchmeats rank next to poultry.

Fish, lamb and veal are purchased less frequently by these city families.

At the time of the survey in 1948, these city families were consuming 10 per cent more meat than families studied in 1942. Lower income families accounted almost entirely for the increase.



## Sliced Delicacies for Holiday Menus

**PORTION  
CONTROLLED**  
*for* **CALORY  
and COST  
CONTROL**

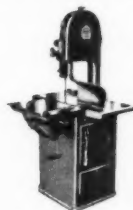


with the New



**MODEL 805**

### U. S. QUALITY FOOD MACHINES



Wells "Quikut" Saw



Tendersteak Machines



Standard Scale



Enterprise Chopper

"Berkel" "Enterprise" "Tendersteak"  
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Smooth, accurate slices of turkey or chicken, either hot or cold, are assured when you use this new U. S. quality food machine. Illuminated "radio dial" makes thickness selection easy and quick, for correct calory control—and helps keep costs in line.

All year long the compact, good-looking Model 805 provides fast, effortless slicing of hot or cold boneless meats, vegetables, fruits, cheese or bread, in any thickness up to 3/4", right down to the last edible slice. Permanently attached sharpener keeps razor-keen edge on high carbon steel knife. Removable tray for receiving and transporting slices.

**Free Cost Control Chart.** Helps you regulate slicing thickness for meats, cheese, vegetables and bread. Mail coupon for Free Chart. Check for information on U. S. Quality Food Machines.

U. S. Slicing Machine Company, Inc., Dept. MM, La Porte, Indiana

Please send me my free "Food Cost Control Card"—also full information on  
☐ U. S. Slicers ☐ Tendersteak Machines ☐ Choppers ☐ Scales ☐ Saws

Name

Street

City  State

# Menus for January 1950

Chloe Finley

Dietitian

T. J. Samson Community Hospital  
Glasgow, Ky.

<p><b>1</b></p> <p>Grapefruit, Cherry Cinnamon Buns</p> <p>•</p> <p>Strawberry Punch Relishes</p> <p>Broiled Ham, Pineapple Parsley Potatoes Creamed Peas, Patty Shells Concocted Cranberry Salad Shamrock Rolls Pecan Pie</p> <p>•</p> <p>Bacon-Tomato Sandwiches Potato Salad Cherry Ice Cream</p>	<p><b>2</b></p> <p>Stewed Prunes, Lemon Soft Eggs on Toast</p> <p>•</p> <p>Pot Roast of Beef Franconia Potatoes and Carrots Sweet Relish Apricot Halves</p> <p>•</p> <p>Escalloped Cheese and Asparagus Baked Potatoes on the Half-Shell Salad Greens Lemon Custard</p>	<p><b>3</b></p> <p>Tomato Juice Scrambled Eggs</p> <p>•</p> <p>Creamed Chicken on Hot Biscuits Green Beans Buttered Corn Celery Hearts Kadota Figs</p> <p>•</p> <p>Homemade Vegetable Soup Tuna Casserole Perfection Salad Frosted Cup Cakes</p>	<p><b>4</b></p> <p>Orange Halves Bacon</p> <p>•</p> <p>Roast Fresh Ham Hominy Grits Glazed Parsnips Tossed Salad Greens Prune Whip</p> <p>•</p> <p>Chicken Goulash Stuffed Pear Salad Strawberry Bavarian Cream</p>	<p><b>5</b></p> <p>Stewed Apricots Coddled Eggs</p> <p>•</p> <p>Meat Loaf, Tomato Sauce Oven Browned Potatoes Buttered Kale Shredded Carrot and Coconut Salad Peach Halves</p> <p>•</p> <p>Macaroni-Cheese Casserole Buttered Asparagus Chef Salad Date Pudding, Hard Sauce</p>	<p><b>6</b></p> <p>Grapefruit Juice Rice Cakes, Sirup</p> <p>•</p> <p>Broiled Lemon Sole, Tartare Sauce Baked Potatoes Buttered Fresh Spinach Sliced Tomatoes Southern Cornbread Chocolate Tapioca</p> <p>•</p> <p>Baked Beans Stuffed Prune and Pineapple Salad Homemade Sugar Cookies</p>
<p><b>7</b></p> <p>Apple Juice Soft Boiled Eggs</p> <p>•</p> <p>Sautéed Liver Snowflake Potatoes Green Peas Corn Relish Hot Bran Muffins Fruit Cocktail</p> <p>•</p> <p>Creamed Sweetbreads on Toast Spiced Peach Salad Ginger Bread With Lemon Sauce</p>	<p><b>8</b></p> <p>Bananas Toast, Grape Jelly</p> <p>•</p> <p>Oven Roast of Veal Sweet Potatoes en Casseroles Julienne Green Beans Fruit Perfection Salad Maple Ice Cream</p> <p>•</p> <p>Escalloped Potatoes Tuna Salad, Celery Hearts Tokay Grapes</p>	<p><b>9</b></p> <p>Grapefruit Juice Scrambled Eggs</p> <p>•</p> <p>Meat Patties Blackeyed Peas Sweet Turnip Greens Sweet Cucumber Pickles Strawberry Shortcake</p> <p>•</p> <p>Ham-and-Corn Pudding Potato Rosettes Concocted Vegetable Salad Jelly Roll</p>	<p><b>10</b></p> <p>Apple Sauce Bacon</p> <p>•</p> <p>Shepherd's Pie Frozen Green Peas, Carrots Lettuce Salad Oatmeal Cookies</p> <p>•</p> <p>Vegetable Soup Baked Potatoes on Half- Shell, Sliced Cheese Grapfruit and Avocado Salad Steamed Fig Pudding</p>	<p><b>11</b></p> <p>Pineapple Juice Soft Cooked Eggs</p> <p>•</p> <p>Swiss Steak Green Lima Beans Sliced Beets Orange-Cabbage Salad Stewed Apricots</p> <p>•</p> <p>Italian Spaghetti Steamed Buttered Celery Chef Salad White Layer Cake With Icing</p>	<p><b>12</b></p> <p>Tomato Juice French Toast, Sirup</p> <p>•</p> <p>Broiled Sausage Patties Baked Acorn Squash Buttered Green Peas Tossed Salad Orange Slices, Coconut</p> <p>•</p> <p>Creamed Dried Beef Potato Patties Head Lettuce, 1000 Is. Dr. Toll House Cookies</p>
<p><b>13</b></p> <p>Orange Juice Baked Eggs</p> <p>•</p> <p>Creamed Baked Haddock Buttered Potatoes Steamed Spinach Celery Curls Cornbread Muffins Citrus Fruit Cup</p> <p>•</p> <p>Cream of Tomato Soup Cheese Fondue Spring Salad Bowl Dutch Apple Cake</p>	<p><b>14</b></p> <p>Apricot Nectar Soft Cooked Eggs</p> <p>•</p> <p>Roast Beef O'Brien Potatoes Baked Yellow Squash Radish Ropes Stewed Prunes With Whipped Cream</p> <p>•</p> <p>Cream of Asparagus Soup Hamburgers on Buns Combination Veg. Salad Butterscotch Pudding</p>	<p><b>15</b></p> <p>Grapefruit Halves Bacon, Waffles</p> <p>•</p> <p>Baked Ham, Raisin Sauce Mashed Potatoes Brussels Sprouts Stuffed Apple Salad Pineapple Sherbet</p> <p>•</p> <p>Stuffed Tomato Salad Deviled Eggs Steamed Potatoes Carrot Curls Bananas With Milk</p>	<p><b>16</b></p> <p>White Grapes Coddled Eggs</p> <p>•</p> <p>Roast Leg of Lamb, Mint Jelly Buttered Browned Potatoes Green Beans Endive, Fr. Dressing Apricot Halves</p> <p>•</p> <p>Chicken Noodle Soup Sweet-Sour Beets Canadian Bacon Waldorf Salad Caramel Cream Pie</p>	<p><b>17</b></p> <p>Fresh Orange Juice Hot Biscuits, Jelly</p> <p>•</p> <p>Meat Pie Hashed Browned Potatoes Glazed Carrots Celery Hearts Soft Sugar Cookies</p> <p>•</p> <p>Cheese Soufflé Green Peas Pear-Orange Salad Fudge Cake</p>	<p><b>18</b></p> <p>Apple Juice Omelet</p> <p>•</p> <p>Veal Birds, Rice Beets With Harvard Sauce Raw Vegetable Strips Prune-Apricot Upside- Down Cake</p> <p>•</p> <p>Oyster Stew Tomato Aspic With Cream Cheese Dressing Sliced Cold Meat Half-Moon Apple Pies</p>
<p><b>19</b></p> <p>Pineapple Juice Scrambled Eggs</p> <p>•</p> <p>Broiled Steak Mashed Potatoes Buttered Cauliflower Fruited Slaw Stewed Prunes With Whipped Cream</p> <p>•</p> <p>Cottage Cheese and Nut Croquettes Mushroom Sauce Stuffed Baked Potatoes Head Lettuce, 1000 Is. Dr. Orange Upside-Down Cake</p>	<p><b>20</b></p> <p>Baked Apple Bacon</p> <p>•</p> <p>Chicken With Dumplings Buttered Green Peas Julienne Carrots Vegetable Aspic Rice Pudding With Raisin Sauce</p> <p>•</p> <p>Eggs à la King in Patty Shells Asparagus, Grated Cheese Frozen Fruit Salad Cherry Cobbler</p>	<p><b>21</b></p> <p>Pear Juice Soft Cooked Eggs</p> <p>•</p> <p>Roast Pork Tenderloin Potatoes in White Sauce Eggplant à la Creole Mustard Pickles Hot Bran Muffins Pumpkin Pudding</p> <p>•</p> <p>Spanish Rice Green Beans-Carrot Salad Date Loaf, Custard Sauce</p>	<p><b>22</b></p> <p>Fresh Pineapple Cones Pancakes, Maple Sirup</p> <p>•</p> <p>Baked Turkey, Dressing Broccoli, Hollandaise Sauce Cranberry Salad Hot Biscuits Raspberry Ice Cream</p> <p>•</p> <p>Cream of Potato Soup Assorted Sandwiches Sweet Gherkins Purple Plums Clover Leaf Wafers</p>	<p><b>23</b></p> <p>Grapefruit Half Poached Eggs on Toast</p> <p>•</p> <p>Salmon Loaf Mushroom Sauce Creamed Peas and Potatoes Tomato Wedges Peach Short Cake</p> <p>•</p> <p>Welsh Rabbit on Toast Boiled Potatoes Stuffed Prune and Orange Salad Danish Pastry</p>	<p><b>24</b></p> <p>Loganberry Nectar Bran Muffins, Apple Butter</p> <p>•</p> <p>Old Fashioned Beef Stew Spinach Salad With Bacon Dressing Corn Bread Sticks Fruit Tapioca</p> <p>•</p> <p>Chow Mein With Noodles Molded Egg Salad Banana Pudding</p>
<p><b>25</b></p> <p>Stewed Figs Bacon Omelet</p> <p>•</p> <p>Broiled Lamb Chops Snowflake Potatoes Baked Squash Tomato Wedges Rhubarb Sauce</p> <p>•</p> <p>Black Bean Soup Creamed Ham and Pepper on Toast Salad Greens Mincedmeat Cobbler</p>	<p><b>26</b></p> <p>Vegetable Juice Cocktail W. W. Muffins, Bacon</p> <p>•</p> <p>Stuffed Baked Heart Duchess Potatoes Green Beans Sliced Beets Fresh Fruit Cup</p> <p>•</p> <p>Corn Pudding Buttered Asparagus Banana-Pearut Butter Salad Maple Bavarian Cream</p>	<p><b>27</b></p> <p>Baked Apple Soft Scrambled Eggs</p> <p>•</p> <p>Fried Sea Bass Steaks Lemon Slices Steamed Potatoes Buttered Cabbage Glazed Carrots Apple Dumpling</p> <p>•</p> <p>Toasted Pimiento Cheese Sandwiches Boiled Egg Halves and Black Olives on Endive Mahogany Cake</p>	<p><b>28</b></p> <p>Stewed Apricots Soft Cooked Eggs</p> <p>•</p> <p>Smothered Steak Hashed Browned Potatoes Stewed Tomatoes Carrot Straws Peach Soufflé</p> <p>•</p> <p>Creamed Diced Liver on Toast Baked Potato Grapefruit-Orange Salad Chocolate Pudding</p>	<p><b>29</b></p> <p>Fresh Orange Juice Jelly Omelet</p> <p>•</p> <p>Fried Chicken Mashed Potatoes Buttered Green Peas Pineapple-Cheese and Prune Salad Cherry Garden Ice Cream</p> <p>•</p> <p>Homemade Vegetable Soup Stuffed Egg Salad Rice Pudding, Fruit Sauce</p>	<p><b>30</b></p> <p>Purple Plums Poached Eggs on Toast</p> <p>•</p> <p>Meat Balls Spaghetti Fresh Spinach Lemon Circles Sweet Relish Canned Peas, Wafers</p> <p>•</p> <p>Oyster Stew Old Fashioned Escalloped Potatoes Kadota Fig-Cream Cheese Salad Apple Betty</p>

**31** Tomato Juice, Scrambled Eggs • Oven Roast of Beef, Creamed Potatoes, Buttered Celery, Diced Carrots, Ice Box Cookies • Creamed Tuna and Peas on Toast, Spoon Bread, Peach and Lime Gelatin, Salad, Banana Ice Cream

Ready-to-eat or cooked cereals are offered on all breakfast menus.  
Milk is offered each meal.

# ONLY GARLAND THE LEADER

**HAS FRONT FIRED HOT TOPS—**



## Heavy Duty Ranges...and...Restaurant Ranges Too!

*Not two, not four, but seven Front Fired burners provide unmatched flexibility of heat control.*

*Front Fired multi-jet burners with ceramics heat each top section.*

Garland Front Fired Burners give flexibility over a greater area of the cooking top than other burners. You get high heats at the front of the cooking top with receding heats toward the rear. Many heats for many jobs on the same top at the same time—from the same burners. And be-

cause every burner is individually controlled you can vary your heat from *side to side* too.

Kitchen operators everywhere place Garland *first*; *proof* that your choice of Garland is the *right* choice! Leading dealers from coast to coast handle Garland. Buy from the one nearest you.

*All Garland units are available in stainless steel and equipped for use with manufactured, natural or L-P gases.*

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**THE TREND IS TO GAS**

**FOR ALL COMMERCIAL COOKING**

**Heavy Duty Ranges • Restaurant Ranges • Broilers • Deep Fat Fryers • Toasters  
Roasting Ovens • Griddles • Counter Griddles**

**PRODUCTS OF DETROIT-MICHIGAN STOVE CO., DETROIT 31, MICHIGAN**

\*REG. U. S. PAT. OFF.

## PLANNING THE HOSPITAL LAUNDRY

GLENN R. STUDEBAKER

Hospital Consultant, Division of Medical and Hospital Resources  
Public Health Service  
Federal Security Agency

### LOCATION

**P**RESENT design practice is to centralize the mechanical services of a hospital in one location and in conformity with local building codes and laws. The services grouped are usually the boiler and pump room, maintenance shop, laundry and garage. Such centralization will result in less initial investment for building and equipment. It is a major factor in lowering operating costs and promoting efficient operation. It also has considerable administrative value. The occasional disadvantages, such as excessive heat during the summer and the increased use of supplies owing to infiltration of dirt from the boiler room, where coal is used for fuel, can be corrected by adequate ventilation and screening.

Ideally, all of the mechanical services of a hospital should be installed in a separate building located as far as practical from the patient service areas in order to reduce noise and dirt. However, it is the exceptional community that has sufficient funds to permit the construction of a detached building for housing these services. Most hospitals of less than 100 bed capacity locate these services in the basement and at the rear of the main building. Hospitals of more than 100 beds more often can afford expenditures for a separate service wing. Traffic to and from the laundry should be routed to keep entrances into administrative and patient areas at a minimum.

### FINISHES

**1. Ceilings:** Laundry ceilings should be moisture resistant and have a high light reflecting factor. In the event the laundry is so located that soundproofing is desirable, the materials selected for this purpose should be moisture proofed. Ceiling heights should be not less than 11 feet from finished floor.

This is the second and concluding section of an article on Planning the Laundry. The first section appeared in the November issue.

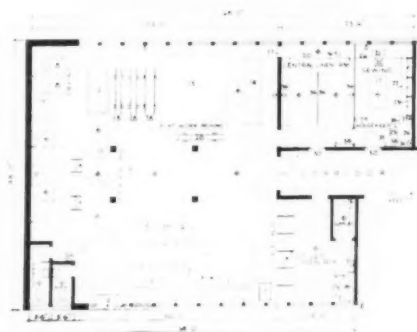
**2. Floors:** Laundry floors are usually of dustproof smooth finish concrete or material of an equivalent nature and are pitched at the time of construction to permit a quick easy drainage. It is important that pitches be provided as this will prevent water from pooling on the floor with consequent slipping hazards to the personnel and the creation of unhealthful and unsightly conditions. Adequate drainage trenches must be provided for the washers and extractors.

For the protection of the workers, lattice-type wood mats may be placed at the working stations of the several machines. These have the advantage of being easily cleaned and dried. They prevent slipping on the part of the workers and reduce fatigue for those who must stand continuously.

**3. Walls:** All walls should be hard surfaced. In case material other than a light reflecting tile is used, painting with a good grade of aluminum or other metallic base paint will prove

LAUNDRY FOR A 200-BED GENERAL HOSPITAL 1/

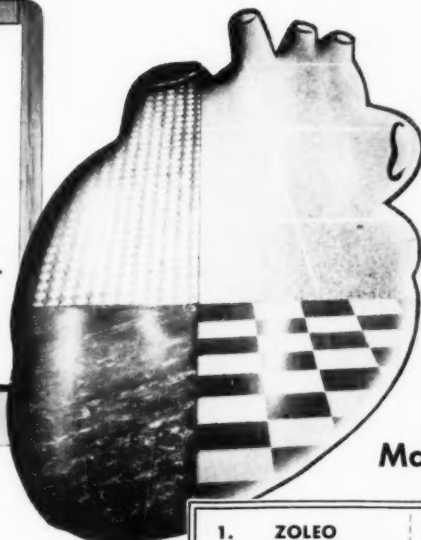
Suggested Equipment Layout Plan



Fixed Equipment List (Group I)

Laundry for a 200-Bed General Hospital. 1. Metal washer, 24 by 36 in. 2. Metal washer, 12 by 24 in. 3. Soap tank, 90 gal. 4. Double compartment laundry trays. 5. Starch cooker, 25 gal. 6. Extractor, 1 1/2 in. 1 1/2 in. 7. Platform scale, flush with floor. 8. Tumbler, 36 by 30 in. 9. Uniform rack. 10. Ironing board. 11. Utility press. 12. Shakedown table with sloping sides. 13. Flat work counter, 4 ft. 120 in. 14. Table, 36 by 144 in. 15. Shelving. 16. Marking machine. 17. Tables, 1 3/4 by 60 in. 1 3/4 by 45 in., 1 3/4 by 72 in. 18. Shelf over table. 19. Sizing box. 20. Counter, 36 in. high with shelving below. 21. Sewing machine. 22. Counter, 30 in. high with cabinets below. 23. Wall cabinet. 24. Filing cabinets below counter. 25. Straight chair. 26. Counter, 30 in. high open below with drawers. 27. Telephone outlet. 28. Food rack. 29. Hook strip. 30. Dutch door. 31. Floor drain. 32. Compressor. 33. Bulletin board. 34. 24 by 24 in. 35. Waste paper receptacle. 36. Sump. 37. Shelving with bins. 38. Floor window. 39. Gate. 40. Water cooler.

FLOORS  
are the  
"HEART"  
of Hospital  
Sanitation



...care for them  
with WEST  
Maintenance Products

Your floors, like the human heart, are vulnerable to the effects of neglect or indifferent treatment. To avoid shortening their "life-span" and increasing your sanitation overhead, wisely choose West floor products. Special care and treatment with West floor maintenance materials *prolongs the life* and beauty of your floors at an absolute minimum cost.

The strain on your budget is reduced because West Products, formulated for cleaning, sealing and preserving floors, are noted for their long-lasting efficiency—enabling you to protect all floors with the least time and effort.

*Our trained representative will be glad to demonstrate any West product desired. No obligation!*

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OF HOSPITAL SANITATION**

**1. ZOLEO**

**Cleans** Cork, Tile, Wood, Linoleum, Marble, Terrazzo Floors and painted or varnished surfaces.

Liquid soap with Linseed Oil Base, mixes with cold water instantly. Softens dirt, loosens grease and grime with fast emulsifying action.

**2. WESTOLITE**

**Cleans** Cement, Concrete, Tile, Mastic, Asphalt, Slate, Quarry, Marble and unpainted Wood floors.

Balanced cleaning powder dissolves completely and quickly in water. Emulsifies many times its weight in grease. No scrubbing necessary. No suds to rinse. Safe to use, will not injure, stain or scratch surfaces.

**3. CORO-NOLEUM**

**Disinfects and Deodorizes as it Cleans** all floors except rubber, soft mastic, or asphalt base tile.

Phenol coefficient of 7.5. Helps kill many germs and aids in the protection of Health. Ideal for operating rooms, washrooms and special wards. Economical to use.

**4. LUSTRECLEAN**

**Cleans, Deodorizes and Lightly Waxes** Wood, Mastic, Linoleum, Cement, Terrazzo, Composition Tile, Asphalt Tile, Painted and Varnished Floors.

Essentially a cleaner but leaves a fine film of wax on surface. Deodorizing properties make Lustreclean a triple purpose product. Excellent for floors, walls and painted surfaces.

**5. KWYKWAX**

**Waxes and Finishes** all types of floors, except Terrazzo.

No rubbing or polishing necessary. Dries in 20 minutes (or less) with a high hard lustre, which resists traffic wear, protecting floor surface.

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*Company*

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42-16 West Street, Long Island City 1, N. Y.

Gentlemen:

Please send me Free samples and literature of following product numbers: 1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐

Kindly have your trained representative call to arrange a free, non-obligating demonstration ☐

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Position \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_



"The boss bought one of those new HILD Floor Machines with all the special attachments. I can use it to scrub, wax, polish, buff, sand, steel-wool or grind any floor in the place.

"What I really like about the machine is the time it saves. Now I can get around to do ALL the jobs that need doing. It's easy because the machine moves so fast. And then, too, the brush attachment for scrubbing makes a big difference. They call it a *Shower-feed Brush*. It showers an even spray of soap solution onto the floor beneath the entire area of the brush. This provides a larger area of suds action . . . instantly. And this speeds up the scrubbing job.

"And the machine is so easy to operate that you don't get half as tired. That's because the HILD Machine is self-propelled and action-balanced.

"But it's not only that the job is easier. It's a real satisfaction to do a job well. And this machine does just that. Yessie! I'm sold on HILD. And I'm sold on my job now, too."



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satisfactory. By use of these paints and light colors, a high resistance to moisture and good light reflection at a low cost can be obtained.

4. *Windows:* To ensure maximum light and natural ventilation the greatest possible window area should be provided. The windows selected should be capable of at least 50 per cent opening and should be easy to maintain.

5. *Ventilation:* Because the laundry is generally located in the basement or a service wing of the hospital and is placed adjacent to the boiler room, adequate ventilation is essential. Failure to allow for proper ventilation has an adverse effect on the employees' ability to work.

Regardless of the type and kind of ventilating equipment used, it should be of sufficient capacity to provide 20 complete air changes per hour in the hot weather periods. Present practice is to hold to a minimum of 10 complete air changes per hour. It is recommended, however, that equipment installed be of sufficient capacity to provide the maximum of 20 complete air changes, and have two-speed control for summer and winter ventilation.

Where cross ventilation can be achieved and outside air is available, a simple exhaust fan, located preferably in the roof, will meet the need. For laundries located in basements or where proximity to a boiler room creates a definite heat hazard, more elaborate systems will be required and a competent heating or ventilating engineer should be consulted.

Hoods over flatwork ironers are strongly recommended.

6. *Lighting:* Good lighting is as important as the ventilating of the laundry. Studies made of laundry operation have demonstrated that failure to provide proper lighting not only results in lessened productivity and inferior quality of work but is a major cause of accidents.

Particularly where the hospital's operating budget and location do not permit any great selectivity as to the physical condition and age of employees, it is recommended that a thorough study be made by a competent illuminating engineer. The local power company will often be in a position to provide this service and should be consulted. The three systems of lighting in general use—direct, indirect and semi-indirect—should be investigated and the relative merits of each for the

hospitals in conformity with these particular installations should be considered.

Where a minimum of daylight is available, as in basement areas, fluorescent lighting is suggested. All painted surfaces should have reflecting values ranging from 0.74 to 0.81 (cream—ivory—white).

#### SUPPLIES

Expenditure for laundry supplies at present-day prices will usually approximate \$0.40 per 100 pounds of linen washed. This includes soap, starches and similar materials.

#### OPERATING EFFICIENCY

Inasmuch as the efficiency of the laundry affects the services to patients, administration and hospital costs, the following points are emphasized:

1. Layout of the equipment designed to conserve labor and permit shifting of workers from one type of work to another.

2. Purchase of equipment that has long life, is easily accessible for maintenance, requires a minimum of repairs, and has sufficient excess capacity to permit handling of emergency loads.

3. Adequate provision for toilet, shower, locker and restroom facilities for personnel in compliance with state and local health and labor laws and requirements.

Schematic plans have been developed and published by the Division of Hospital Facilities, U.S. Public Health Service,<sup>1</sup> for use as guides in planning and for the installation of fixed (capital) laundry equipment. These plans cover suggested space and layout requirements for new construction in general hospitals with bed capacities of 50, 100 and 200 beds. They embody current thinking as to laundry layout, space requirements, size and amount of fixed equipment, and have been developed from extensive research. In the development of these plans, numerous consultations with architects, hospital consultants, administrators, laundry operators, and representatives of the laundry machinery industry were held, and the field of published material relating to laundry operation and equipment was covered.

Also available are comprehensive lists of laundry equipment and supplies for 50, 100 and 200 bed general schematic plans.<sup>2</sup>

<sup>1</sup>Hospitals, May 1946.

<sup>2</sup>Published in the Hospital Purchasing File, 25th (1947-1948) edition, Modern Hospital Publishing Co., Chicago.



## Modern Laundry Service Cuts Costs

at the Methodist Church Home  
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## WHAT IT TAKES TO BE A HOUSEKEEPER

*and how to go about it*

THE demands of any job determine the background of education and experience necessary. It is generally agreed that every experience is of value to the executive housekeeper and the more education we have the better.

Some of the requirements presuppose special training which many of us did not get in our school days, so we have had to learn the hard way. We should know a bit about psychology to help us get along with all sorts of people. There is much teaching to be done, as well as directing and supervising, so training along these lines is valuable. Some information on accounting principles is most useful for pay roll, budget and linen inventories. We need to know the foundation principles of decoration, to have some knowledge of textiles and also some experience in testing and choosing the right equipment and products to take care of the various types of floors, walls and furniture under our care.

### EXTENSION COURSE APPRECIATED

These are only a few of the things we need to know, so we appreciate greatly opportunities like this extension course to supplement our practical experience. Those of us who have been in this work for some time are interested in seeing that professional standards are recognized as necessary and we want to know where newcomers can obtain the right training.

Some schools and colleges have recognized the opportunity executive housekeeping offers their graduates and have planned courses that will be of real help. Foremost among these is Cornell University, which includes housekeeping as a vital part of its four-year hotel administration course, and also of the summer session.

Teachers College, Columbia University, has an excellent course because the students are given the opportunity for actually working in New York

City hotels, hospitals and college residence halls.

For those who can go to Washington, D.C., good training is given under actual hotel conditions by the Lewis Hotel Training Course.

Many of the state colleges seem to have neglected the housekeeping department of the hotel in their courses.

Some housekeepers who attended the N.E.H.A. biennial congress in Denver had a chance to visit the Emily Griffith Opportunity School. Its courses in hotel and hospital training are excellent. Colorado seems to be hotel minded, for the University of Denver has a four-year hotel management course and the hotel association gives one also.

The New York State Institute of Applied Arts and Sciences offers a hotel residence section in its hotel technology curriculum. The students have actual hotel experience and co-operating hotels find them interested and good workers. This organization took over a resort in New York State last summer. It is said to have been a huge success. I understand Chicago is hoping to do a similar job.

Yale has a department of public health course in hospital administration in its school of medicine, but I am told that not much emphasis is placed on housekeeping.

The American Hospital Association held a short course in hospital housekeeping at Michigan State College in East Lansing from April 4 through May 27 this year. Ten courses of study were covered during the eight weeks, with lectures, discussion and quiz periods for theoretical study and laboratory periods for practical application. The courses included: philosophy of hospital care and institutional organ-

**MRS. GRACE BRIGHAM**  
Executive Housekeeper  
Sheraton-Biltmore Hotel  
Providence, R. I.

ization; personnel management; job analysis; housekeeping supplies; equipment and procedure; linens, furnishings and decorations; bacteriology; fire prevention and safety; practical speaking; budgeting and record keeping; employe training, and general cleaning.

The University of Maryland is planning to inaugurate a full four-year course in executive housekeeping in the home economics department in the near future. The N.E.H.A. has given a \$500 scholarship to be placed at disposal of the dean of the school to help potential housekeepers through the course.

Obviously there are some opportunities for study in various parts of the country but there should be more and better training in our particular duties available to those who want to enter this field. Perhaps other colleges will follow the example of Boston University and establish similar extension courses.

### NUMEROUS OPPORTUNITIES

Opportunities for executive housekeepers should be numerous for there is increasing recognition of the need for well-trained, intelligent women to head such departments in college residence halls, new or enlarged hospitals, in hotels that are working toward complete renovation, in the new airport hotels and the fine motels throughout the country. For those who want to travel, American hotels are being built in several South American countries, Puerto Rico and other Caribbean islands.

The chief problem for the beginner is how to get started, because the first question is: "What has been your experience?" My advice is to take whatever job will give you a toe-hold in the

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*Note to housekeepers: Our free booklet, "Beauty Secrets From Your Linen Closet," is full of helpful information for you. Write Dept. MH-15.*



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hotel, even if it is in another department as food checker, pay roll clerk, or any other position which you can hold. This enables one to see the inner workings of the institution, to realize how necessary close cooperation between departments is and to be ready for a switch to housekeeping when the chance comes. Often starting in a small hotel is helpful and possible before there is a job in the biggest and best.

Seasonal hotels appeal to those who like a change of scene—South in the winter, mountain or seashore in the summer with a month between times sounds good, but they tell us that the strain of opening a house, going at top speed for the season, and then closing it again leaves one sadly in need of that breathing spell.

## II—HOSPITALS

**H**OSPITALS have been slow in establishing housekeeping as a complete department and housekeepers as executives. It is amazing how many hospitals have yet to recognize the importance of a separate housekeeping department set up and supervised by a qualified person who knows what the departmental needs are.

Gradually, changes are being brought about so that there is a growing need for well educated women for this field. Any person who has had hotel training or who is a graduate nurse or a dietitian is a natural for hospital housekeeping. I feel that a hotel trained woman is the best, but the hotel trained woman has to be versatile enough to fit herself and her training into a hospital organization. The two are quite different.

A graduate nurse also has a splendid background for the position of executive housekeeper, *only after she has been trained as a housekeeper*. I know, for I am a graduate nurse, but I know too well that nurse's training in itself is not enough. However, it helps considerably in recognizing and appreciating hospital needs. A dietitian also has a splendid background, but here, again, she has not studied housekeeping in all detail, and must have her education supplemented if she is to make a good housekeeper.

As is true in hotels, one cannot always begin at the top in hospitals in spite of education and experience. One often must start in a linen room, work

Salaries range from \$650 per year, in small hotels, to \$6500 per year usually with full maintenance. There seems to be no standard. Apparently neither size nor kind of institution is the deciding factor. The law of supply and demand plays some part as do the wage differentials of various parts of the country, but we must also admit that the lower pay is usually because there are still hotel managers and hospital administrators who do not have, and do not recognize the need for, a real executive in this position. They are gradually learning that a good salary to a real executive is well worth while because such a woman saves them many a headache and helps greatly when she is allowed to prove her executive ability.

### MRS. MILDRED F. O'DONNELL

Executive Housekeeper  
Mount Auburn Hospital  
Cambridge, Mass.

up to being an assistant and then to an executive position.

Salaries are not dependent upon bed capacity alone. Consideration must be taken of all areas which are to be supervised by a housekeeper, *i.e.* outpatient departments, housing for nurses, interns, staff, laboratory, public rooms and offices. To say a hospital has 250 beds does not give an adequate picture of the responsibilities entailed. Therefore, bed capacity plus other areas must be taken into consideration when salaries are arrived at.

Like hotels, hospitals do not seem to have a definite scale for salaries. At the moment the Parkinson Report is in the making. Perhaps something definite will be concluded after the survey is over. Regardless of the findings, we shall still be dependent upon individual policies of hospital administration and localities.

Here in Massachusetts I find that the usual wage for the executive housekeeper in an average hospital begins at about \$40 per week, sometimes with maintenance, sometimes without, and graduates according to the size of the institution. Assistant housekeepers' salaries begin at \$30 per week and go up from there. In the Middle West the salaries do not seem to be as good as those in the Eastern states, and in California the salaries may be slightly higher but the living conditions more or less equalize them.

I believe that the housekeeper's opportunities are what she makes them.

To me it is better to be a really good housekeeper in a small hospital than a poor one in a large institution.

Every person owes it to herself and her institution to know all there is to be known about every phase of the work. She should have a capacity not only to learn but to be able to apply that learning to advantage. Affiliation with organizations, such as executive housekeeping associations, furthers one's interest in the field and affords proper contacts for discussion and exchange of ideas.

Hospital and hotel journals are a source of information and education. Group discussions with heads of other departments are essential for understanding and cooperation. There are many books on the market that are helpful, including the Dahl publications, H. H. Linn's "School Custodian's Housekeeping Manual," and books on interior decoration for hospitals. These and other volumes of your own choosing should be in your library.

Every person in a housekeeping department, whether maid, linen room woman, seamstress, or whatever her capacity, should be afforded opportunities for advancement in accordance with her abilities. It is well for the housekeeper to attend as many hospital assembly meetings, as well as hotel shows, as possible and to keep her eyes and ears always open for ideas, advice and means by which she can progress.

### YOUNGER WOMEN WELCOMED

Before concluding this discussion I should like to say how glad I am to see younger women coming into this field. We oldsters do not by any means know everything. It is wonderful to find younger women not only coming into the work but doing such a splendid job of housekeeping. We need more young women. It is appalling what a dearth of young women there is in the executive housekeeping field. We need fresh points of view, enthusiasm, such as youth alone has, and the prospects of unlimited opportunities for a future such as we older women cannot have.

Executive housekeeping is as interesting, challenging and rewarding a field as one can find anywhere. To me hospital housekeeping is compensating in two directions: first, it provides a good living and, second, it gives one a chance to serve humanity—even if we must serve in an indirect way.

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## COST STUDIES ANSWER THE CRITICS

(Continued from Page 75.)

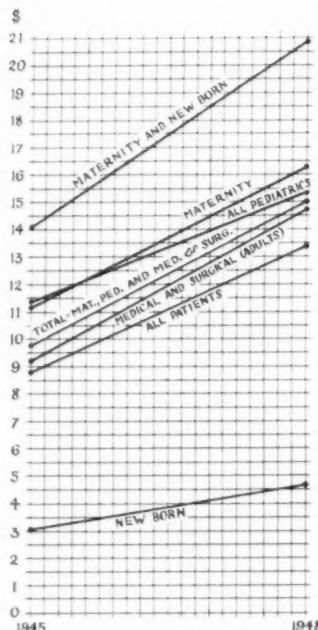
This refinement of patient day costs was repeated in the study for the year ended Sept. 30, 1948.

Table 2 and graph 2 present both this subdivision of costs and also the comparison between these costs for the calendar year of 1945 and the year which ended Sept. 30, 1948.

Costs of special and ancillary services have also been determined in the series of cost studies. Some of these are shown in table 3. The effect of volume on costs is shown in certain services:

1. As a standard, take cost of operations as normal, i.e. volume in 1939 and 1948 was essentially the same, and the unit cost had doubled and a bit more. This is what happened to almost all costs during that 10 year period. (See total costs in table 1 and graph 1 on page 75.)

2. In maternity, volume increased by 75 per cent between 1939 and 1943, but unit costs dropped 20 per cent at a time when costs were increasing generally. A similar situation existed between 1945 and 1948 when volume again increased in maternity service by



Graph 2 Total Costs per Patient Day for the years ended Dec. 31, 1945 and Sept. 30, 1948

30 per cent, but unit costs increased only 15 per cent at a time when costs in general had increased more than 50 per cent. (See table 2 and graph 2.)

3. In x-ray, unit costs actually declined by 20 per cent between 1945 and 1948, when costs in general had increased more than 50 per cent, because the volume had increased about 40 per cent.

4. In the outpatient department, unit costs doubled between 1939 and 1943, when costs in general had increased only 10 to 15 per cent because volume was only one-half as much in 1943 as in 1939.

In the study made for the period ended Sept. 30, 1948, it was learned that the school of nursing costs the hospital between \$40,000 and \$50,000 a year, after applying a liberal valuation for the time served by students in providing nursing service as part of their course of training.

In table 4 are shown the gross costs per student per year, and for the year ended Sept. 30, 1948, is shown also the net cost per student per year.

It will be seen that the total net cost to the hospital was about \$56,000.

TABLE 2.—COST PER PATIENT DAY FOR THE YEARS ENDED DEC. 31, 1945, AND SEPT. 30, 1948

	COST OF BED, BOARD AND ROUTINE CARE		COST OF SPECIAL SERVICES		TOTAL COSTS (INCLUDING SPECIAL SERVICES)		PER CENT OF INCREASE
	Year Ended Dec. 31, 1945	Year Ended Sept. 30, 1948	Year Ended Dec. 31, 1945	Year Ended Sept. 30, 1948	Year Ended Dec. 31, 1945	Year Ended Sept. 30, 1948	
ADULTS AND CHILDREN							
Medical and surgical							
Private.....	\$ 7.21	\$10.87	\$ 2.70	\$ 4.30	\$ 9.91	\$15.17	53.1%
Semiprivate.....	6.02	9.66	2.54	4.61	8.56	14.27	66.7
Ward.....	7.25	11.26	2.39	3.65	9.64	14.91	54.7
Total—Medical and surgical.....	6.67	10.38	2.52	4.29	9.19	14.67	59.6
Maternity							
Private.....	8.90	14.40	2.69	3.71	11.59	18.11	56.3
Semiprivate.....	7.66	11.65	3.07	3.74	10.73	15.39	43.4
Ward.....	8.32	12.42	2.62	4.91	10.94	17.33	58.4
Total—Maternity.....	8.18	12.32	2.85	3.98	11.03	16.30	47.8
Pediatrics							
Private.....	6.95	13.08	4.52	2.53	11.47	15.61	36.1
Semiprivate.....	6.57	10.06	5.81	5.83	12.38	15.89	28.4
Ward.....	7.54	12.42	2.59	2.36	10.13	14.78	45.9
Total—Pediatrics.....	6.99	11.16	4.41	4.27	11.40	15.43	35.4
Total—Adults and children.....	7.01	10.77	2.76	4.23	9.77	15.00	53.5
NEWBORN							
Total—Maternity and newborn.....	3.02	4.58	.....	.....	3.02	4.58	51.7
Total—All patients.....	6.43	9.85	2.36	3.61	8.79	13.46	53.1

TABLE 3.—UNIT COST OF SPECIAL SERVICES 1939—1948

	UNITS OF SERVICE YEAR ENDED					COST PER UNIT OF SERVICE YEAR ENDED				
	12/31/39	12/31/43	12/31/44	12/31/45	9/30/48	12/31/39	12/31/43	12/31/44	12/31/45	9/30/48
Operating room (operations).....	4100	2917	3078	2972	3918	\$14.09	\$19.26	\$19.16	\$22.50	\$29.28
Delivery room (deliveries).....	700	1229	1174	1181	1537	20.30	16.15	18.82	21.02	24.17
X-ray department (films).....	19067	15493	18152	17018	24284	2.13	2.38	2.29	2.71	2.66
Laboratory (tests).....	74955	52906	54901	56863	83555	33	42	56	61	68
Physical therapy (treatments).....	9979	5564	5439	5428	4958	1.02	1.27	1.33	1.45	1.86
Ambulance (calls).....	1310	1164	1126	1257	1137	3.71	4.62	3.50	3.47	4.14
Outpatient department (visits).....	43116	21542	16408	14834	15150	1.82	1.65	2.03	2.12	2.99
Emergency ward (treatments).....	6732	4530	5189	5572	5861	1.46	2.82	2.45	2.83	4.97

For nine-month period—Ambulance service discontinued July 1, 1948.

# Year after year



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### The Milk Every Doctor Knows

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"From  
Contented  
Cows!"

**TABLE 4.—COST PER STUDENT NURSE PER YEAR**

YEAR ENDED	AVERAGE NUMBER OF STUDENTS	COST PER STUDENT PER YEAR
12/31/39	85	\$ 701.52
12/31/43	103	\$ 883.29
12/31/44	121	\$ 887.18
12/31/45	113	\$ 928.44
9/30/48	70 <sup>1</sup>	\$1875.14 <sup>1</sup>
Value of Services (1396 hours at 77c)		\$1074.92 <sup>1</sup>
Net cost,.....		\$0800.22 <sup>1</sup>

<sup>1</sup>On basis of 113 students, cost would be about \$1450

<sup>2</sup>Net cost would then be about,..... 400

**TABLE 5.—LAUNDRY COSTS FOR THE YEARS ENDED DEC. 31, 1939, AND SEPT. 30, 1948**

	YEAR ENDED	
	Dec. 31, 1939	Sept. 30, 1948
Pounds of laundry per patient per day,.....	14.1	12.2
Cost per pound,.....	\$0.0264	\$0.053

However, there were only 70 students in the school for the period studied. Had the student body been 113, which approaches the capacity of the school and was also the number of students enrolled at the time the 1945 cost study was made, the cost to the hospital still would have been about \$45,000.

Some intradepartmental costs are presented in tables 5 and 6.

It may well be asked of what value are these cost figures. A few examples of how these figures have been of value in recent years will serve to answer this question.

### 1. Determination of Rates for the Various Hospital Services

When it was necessary to increase hospital rates, the cost figures were used as a basis for the revision of the rate. In many instances the rates in effect were substantially below cost. The following table will indicate how our cost figures were helpful in setting new rates.

	1944 Average Unit Costs	1946 Rates Charged Prior to Change	New 1946 Increased Rates
Operating room,.....	\$18.82	Range \$ 5.00 to \$20.00	\$12.50 to \$25.00
Delivery room,.....	19.15	Range 10.00 to 15.00	17.50 to 25.00
Nursery,.....	2.63	Range 1.00 to 2.00	2.00 to 3.00
Semiprivate rooms,.....	6.25	Range 5.00 to 7.00	6.00 to 7.50

### 2. More Equitable Payments From Governmental Agencies

Ten years ago the hospital rate for general ward patients was \$5 per day (\$2 for children) plus very small charges for special services. Undoubt-

**TABLE 6.—COST OF FEEDING PATIENTS AND EMPLOYEES FOR THE YEARS ENDED DEC. 31, 1939, AND SEPT. 30, 1948**

	PER MEAL			
	RAW FOOD COST		TOTAL DIETARY COST	
	Year Ended		Year Ended	
	Dec. 31, 1939	Sept. 30, 1948	Dec. 31, 1939	Sept. 30, 1948
Private and semiprivate patients	\$ .223	\$ .471	\$ .332	\$ .795
Ward patients	.160	.420	.238	.744
Special nurses	.141	.407	.238	.731
Nurses, student nurses, executive and office	.142	.420	.240	.744
Help	.122	.387	.194	.711
Average for Year	.136	.435	.247	.759
	Dec. 31, 1945	Sept. 30, 1948	Dec. 31, 1945	Sept. 30, 1948
Medical and surgical patients				
Private and semiprivate	\$ .315	\$ .466	\$ .546	\$ .790
Ward	.218	.426	.450	.750
Maternity patients	.370	.550	.602	.874
Private and semiprivate	.307	.462	.539	.785
Pediatric patient				
Private and semiprivate	.351	.352	.582	.675
Ward	.217	.352	.448	.675

**TABLE 7.—COST PER PATIENT DAY (EXCLUDING NEWBORN) BY DEPARTMENTS AND SERVICES FOR YEARS ENDED DEC. 31, 1939, AND SEPT. 30, 1948**

	Year Ended 12/31/39		Year Ended 9/30/48	
	Cost	Per Cent of Grand Total	Cost	Per Cent of Grand Total
<b>BED, BOARD AND ROUTINE CARE</b>				
Professional care including nursing service, school of nursing, house staff, social service	\$2.45	33.24%	\$ 4.81	32.01%
Medical and surgical supplies, drugs, central supply room	.65	8.81	.97	6.49
Patients' meals	.83	11.18	2.30	15.34
Housekeeping, laundry, linen and bedding, plant operation and maintenance and depreciation of furniture	1.08	14.67	1.62	10.82
Administration	.68	9.17	1.07	7.13
Total —Bed, board and routine care	\$5.69	77.07%	\$10.77	71.79%
<b>SPECIAL SERVICES</b>				
X-ray, laboratory, blood bank, operating room, delivery room, emergency ward, physical therapy, oxygen therapy, electrocardiograph, basal metabolism, special drugs, solutions	1.69	22.93	4.23	28.21
<b>GRAND TOTAL</b>	\$7.38	100.00%	\$15.00	100.00%

edly these rates were at that time about half the actual cost. In the last eight years ward rates have been increased several times to the present generally inclusive rate of \$11 per day. This rate was established in January 1948 after the local municipalities and the county welfare board had refused to pay the hospital at rates which were higher than the established ward rates,

than \$7.50 unless the published rate was also increased. The hospital had requested payment of \$11 per day for the care of welfare patients of its local municipalities and for the old-age assistance clients of the county welfare board.

These agencies would not pay the \$11 until the hospital established its ward rate at \$11. After this rate had been established both the towns and the county without question accepted the new rate of \$11. As one county official stated, "If your costs are \$13 and your published rate is \$13 we could not refuse to pay you \$13 if you asked for it."

### 3. Answers to Criticisms and Misunderstandings

On many occasions when both patients and medical staff members and others have questioned or been critical of hospital rates, the cost studies, which are always in the right-hand drawer of my desk, have served many times to

which were at that time about \$7.50 for all services.

Costs at that time were slightly over \$15 per day. The towns and the county all agreed that the figure of \$13 represented cost but refused to pay more

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dispel misunderstandings, answer criticisms and serve as a means of education on hospital costs.

#### 4. Cost of the School of Nursing

As noted, we believe the school of nursing costs the hospital many thousands of dollars a year. There still exists the feeling among many, and unfortunately in this group are many nurse educators, that a hospital profits from the services provided by the student nurses, even exploits their student nurses. If this were ever true, it certainly has not been true in recent years in this hospital and undoubtedly the same applies in many other hospitals conducting schools of nursing.

Of course, it may be that a poorly conducted, substandard school of nursing may not be a costly venture. Our director of the nursing department thoroughly concurs that to conduct a first-class school of nursing will cost the hospital money.

#### 5. Public Education

Table 7 presents only one of many methods of utilizing cost figures in explaining to community groups, such as community chests, municipal officials, service clubs, how the hospital operates.

#### 6. Determination of Extent of Charity Work

In the determination of cost studies there is also a detailed analysis of income. It is a simple matter therefore to determine from a cost study the extent of "free" services provided by the hospital. Table 8 presents this picture very clearly.

This tabulation points out a current and serious problem faced by voluntary hospitals, namely, that of obtaining adequate income in these days of high expense to pay for free services. In the years prior to and during the war this free service was readily paid for through community chest contributions and "profit" on private patient services. Costs are now at a level which requires such high rates to private and semiprivate patients that it is a serious matter to consider increasing them and there is little so-called profit these days from private patient services. At the same time community chest contributions have not increased the same relative amount as have operating expenses. Accordingly, the voluntary hospital must look to other sources of income, unless it is blessed with a large general endowment fund.

TABLE 8.—LOSS ON CHARITY PATIENTS FOR THE YEARS ENDED DEC. 31, 1939, AND SEPT. 30, 1948

	YEAR ENDED	
	December 31, 1939	September 30, 1948
<b>Costs:</b>		
Care of ward patients	\$221,998 (33,031 days)	\$318,141 (20,112 days)
Dispensary clinics	50,379 (43,116 visits)	67,717 (15,150 visits)
Emergency service	9,844 (6732 treatments)	25,445 (5118 treatments)
Total cost of charity patients	282,221	411,303
<b>Deduct:</b>		
Income received from:		
Ward patients	45,488	118,486
Dispensary patients	11,321	18,170
Emergency patients	3,770	9,845
Total income from charity patients	60,579	146,501
Operating deficit resulting from charity patients	221,642	264,802
<b>Deduct:</b>		
Income received from:		
Governmental agencies	41,208	46,634
Community chests	113,572	140,187
Endowments	14,774	18,791
Donations	7,606	14,787
*Total income for support of charity work	177,160	220,399
Charity Deficit	44,482	44,403

\* It is by no means accepted by all that endowment income and undesignated gifts should be applied to charity deficits.

About the only remaining source of funds is from government to help pay for the services rendered free and part-pay patients in the hospital wards and clinics.

Our cost figures have been used in the last year and a half in presenting to our local municipalities the deficits sustained on ward, clinic and emergency ward services after applying against cost of these services all income received from patients in Blue Cross plans, insurance companies, governmental agencies and community chests. Although so far it has not been necessary for the hospital to request collection of these deficits from the towns they nevertheless have been educated and are on notice that if the hospital operates with a substantial deficit they will be requested to pay toward the deficit sustained on these services.

#### 7. Comparison With Governmental Cost Formula

Our cost figures have shown what we believe to be a weakness in the reimbursable cost formula used by the federal government and developed jointly between the federal government and the American Hospital Association.

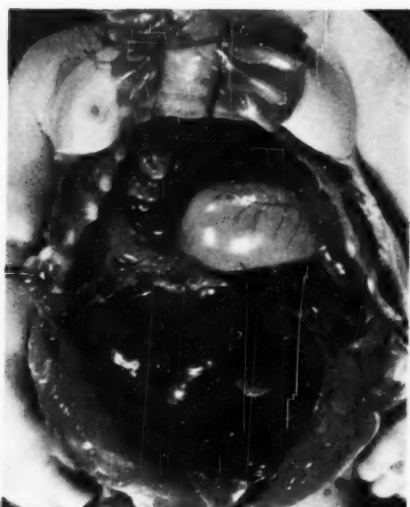
Early this year when submitting revised reimbursable costs to governmental agencies, the cost figure as determined by the formula was \$19.50. This figure was substantially higher than our cost figures for the year ended Sept. 30, 1948. On analyzing this discrepancy it was found that the allow-

able deduction of \$2 per unit of service for clinic and other outpatient service visits for both paying and non-paying patients was too low. Applying the actual cost for various services, such as laboratory, x-ray examinations, clinic visits, and emergency ward visits, the reimbursable cost figure was reduced from \$19.50 to \$16.78.

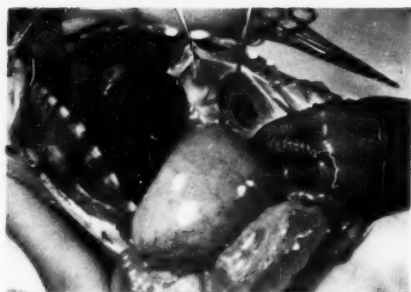
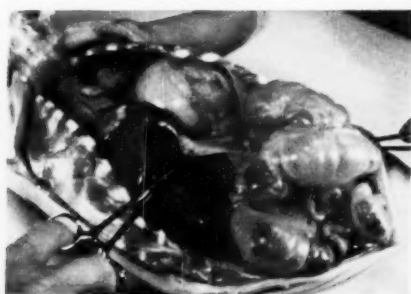
Furthermore, in hospitals where maternity service is conducted, it has always seemed that the hospital was getting more than its actual cost under the reimbursable cost formula. It does not appear equitable to deduct newborn infant days without also deducting the cost of their care from expenses. Accordingly, by deducting our known costs for newborn infant services the reimbursable cost figure was further reduced to \$16.08. The formula was submitted to the Veterans Administration with an explanation of how and why the \$16.78 was reduced to \$16.08. Veterans Administration accepted the figure of \$16.78.

I am a firm believer that government should pay cost for services rendered those for whom it is responsible. I am also of the firm belief that hospitals should not submit "inflated" cost figures such as can happen under the government reimbursable cost formula as is shown in the analysis above.

In conclusion it can be stated that the determination of costs over the period of the last 10 years has convinced the trustees and administrative staff of the Mountside Hospital of the real value of determining as frequently as indicated actual cost figures.

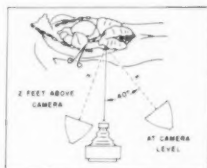


CONGENITAL DIAPHRAGMATIC HERNIA: Post-mortem examination of newborn infant. Kodachrome transparency preserves for further study the many details discovered.



CONGENITAL DIAPHRAGMATIC HERNIA: This reproduction of a Kodachrome transparency and the one above were made at autopsy of a 3-year-old child. The transparencies reproduced here demonstrate clearly the existence of a congenital defect in the posterior portion of the left leaf of the diaphragm.

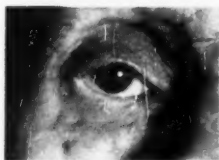
Adequate illumination for subjects such as these is provided by two Kodak Vuri-Beam Standlights arranged as indicated in this diagram.



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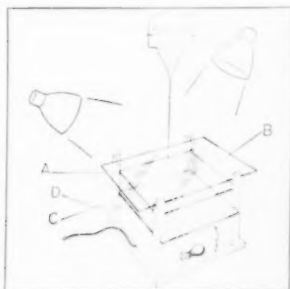


Reproductions (enlarged) of two frames from a 16-millimeter Kodachrome motion picture dealing with the removal and reconstruction of a carcinomatous eyelid.

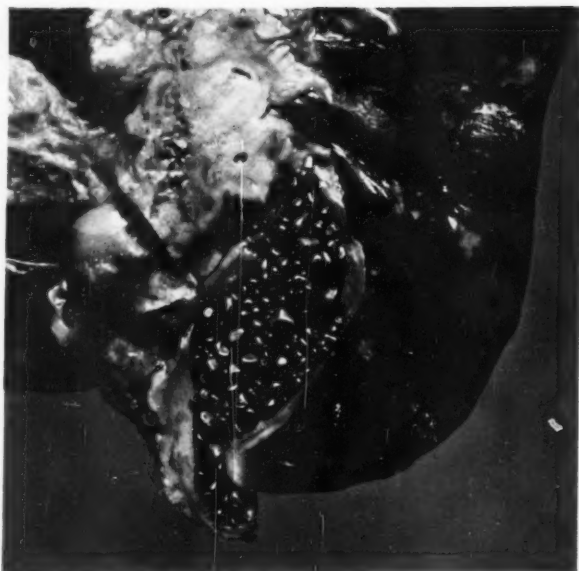
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## Picture the patient's progress (continued)



Diagrammatic representation of specially constructed illuminator used for the photography of gross pathologic specimens with transilluminated colored backgrounds as in the reproduction at right. A—18x24-inch clear plate glass for holding large specimens; B—16x18-inch clear plate glass for supporting average smaller specimens; C—double-flashed opal glass for diffusion of illumination from below; D—16x18-inch transparent glass of proper color to give desired background effect.



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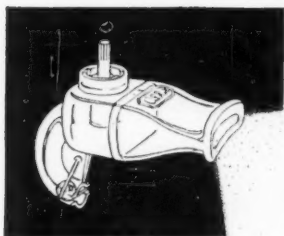
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1. Krasno, L., Karp, M.,  
and Rhoads, P. S. (1948).  
The Inhalation of Penicillin  
Dust, J. Amer. Med. Assn.,  
138:344, October 2.

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# NEWS DIGEST

**Urges Establishment of N.Y. State Hospital Commission . . . Virginia Starts Hospital Administration Course . . . 1600 Attend Ontario Meeting . . . Dr. Bachmeyer Heads Medical College Association . . . Vermont Elects Officers**

## Urges Establishment of N.Y. State Hospital Commission, Expanded Aid

NEW YORK. — Establishment of a New York State Hospital Commission to exercise broad general supervision over all hospitals in the state, including voluntary hospitals, was recommended in the report of the New York State Hospital Study released here November 22 by Dr. Eli Ginzberg of Columbia University, director of the study.

Covering all aspects of hospitalization and hospital finance throughout the state, the study was carried out under an agreement between the university and the State Joint Hospital Survey and Planning Commission. Under the recommendation made by Dr. Ginzberg and his associates on the study staff, the latter group would be reconstituted with broad powers to improve methods of supervising the quality of hospital care.

State subsidies for voluntary hospitals are not needed at the present time, the report said, because "although they are still in a tight financial position, their situation has begun to ease, and, if business conditions remain stable, will continue to improve."

Increased state expenditures for mental and tuberculosis hospital facilities and operations were, however, recommended by the group, which also saw an expanded program of aid for chronic disease patients as a major part of the state's hospitalization responsibilities. Altogether, the recommendations would increase annual hospitalization expenditures by the state by \$22,800,000, more than half of which would be for mental patients.

With only 10 per cent of the nation's population, New York State is spending 16.5 per cent of the national total for hospital care, the study revealed. The recommended increases in state expenditures would add approximately 25 per cent to the state hospitalization budget.

An additional \$48,000,000 will be needed in the next five years for construction of facilities for mental patients, the report indicated. Construction needs also include \$2,000,000 for chronic patients and \$1,500,000 for outpatient clinics.

The recommendation that the state should not aid voluntary hospitals at this time was based on the finding that nearly 60 per cent of the population is now covered by some form of hospitalization insurance or prepayment plan. This figure may eventually reach 85 per cent, it was predicted.

The need for a state hospital commission arose from the fact that 40 per cent of general hospital beds are in institutions not approved for intern training by the A.M.A., and 15 per cent in general hospitals not approved by the American College of Surgeons.

The report also recommended that local governments reimburse voluntary hospitals for outpatient and diagnostic services to public charges. Voluntary groups must recognize their responsibility to make the facilities of voluntary hospitals as available as possible to all competent doctors in the community, the group stated. "The continued operation of the voluntary hospital system depends to a large extent on the expansion of enrollment in hospital prepayment plans that provide adequate coverage to the maximum number of patients," the report stated. Voluntary groups should act cooperatively to ensure the accomplishment of this result in the shortest possible time, it concluded.

The report has been published in book form by the Columbia University Press under the title, "A Pattern for Hospital Care." Dr. Ginzberg is associate professor of economics.

## Hospital Administration Course Inaugurated at Medical College of Virginia

RICHMOND, VA.—A school of hospital administration has been established at the Medical College of Virginia, C. P. Cardwell Jr., director of the hospital division of the college here, announced last month. The new school, which has as its purpose the preparation of men and women for careers in the field of hospital administration, will begin instruction Jan. 2, 1950.

Mr. Cardwell will serve as professor of hospital administration. A. J. Howell, former administrator of Raiford Memorial Hospital, Franklin, Va., has been named associate professor and director of the school. He will be assisted by Carl R. Parrish, assistant director of the hospital division, who will serve as assistant professor of hospital administration. In addition, individual lecturers, authorities in their fields, will be called upon to conduct some courses in the curriculum, it was explained.

### 18 MONTHS OF TRAINING

The new course will consist of 18 months of training, the first six months of which will be devoted to introductory classroom instruction with ample opportunity to observe hospital administration and operation. During the second period of 12 months the course will take the form of an internship, a part of which will be obtained at the hospital division of the college and the remainder in smaller cooperating hospitals.

In order to be admitted to the new school, persons must possess at least a baccalaureate degree from an educational institution approved by the college and show evidence of possessing capability and fitness for work in hospital administration.

The course at Virginia is the twelfth such program to be established.



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## NEWS...

### 1600 Attend 25th Anniversary Meeting of the Ontario Hospital Association

TORONTO, ONT.—There is no place on hospital boards of trustees today for the inactive "rubber stamp" trustee whose participation is limited to occasional attendance at board meetings. Prof. M. B. Baker, a trustee of the Kingston General Hospital, Kingston, Ont., stated at one of the meetings of the 25th anniversary of the Ontario Hospital Association here last month. More than 1600 association members registered for the convention which featured a special conference for trustees.

The hospital board is a legislative, judicial policy-making group, Prof. Baker said, whose responsibility it is to guarantee good patient care and protect patients against any kind of exploitation. Hospital boards always benefit from the addition of alert new members, Prof. Baker added. He opposed board appointments for indefinite terms and recommended that new trustees be elected regularly and then familiarized with all phases of hospital operation through a systematic education program.

In another presentation at the trustees' conference, William Loveday of the Victoria Hospital at London, Ont., said that while the board must retain final control it should delegate complete authority and responsibility to its chief executive officer, the administrator. Board members should be discouraged from entering into details of hospital operation and should communicate with department heads and members of the medical staff only through the administrator, Mr. Loveday declared.

Dr. W. Douglas Piercy of Ottawa took office as president of the association during the meeting, succeeding Pearl L. Morrison of Toronto. John R. Marshall of Peterborough was named president-elect to succeed Dr. Piercy. Other officers of the association elected were: first vice president, R. J. Weatherill, St. Catharines; second vice president, Sister Louise, Toronto; third vice president, C. N. Weber, Kitchener; secretary-treasurer, Dr. Fred W. Routley, Toronto, and associate secretary-treasurer, A. J. Swanson, Toronto.

The Dominion Government of Canada recognizes the fact that hospitals throughout the nation are suffering from the shortage of staff nurses and is prepared to assist the hospitals, Dr. G. D. W. Cameron, deputy minister of health and welfare, told the association.



Pearl Morrison (right), retiring president, with Dr. Cameron, and Mrs. Hartness.

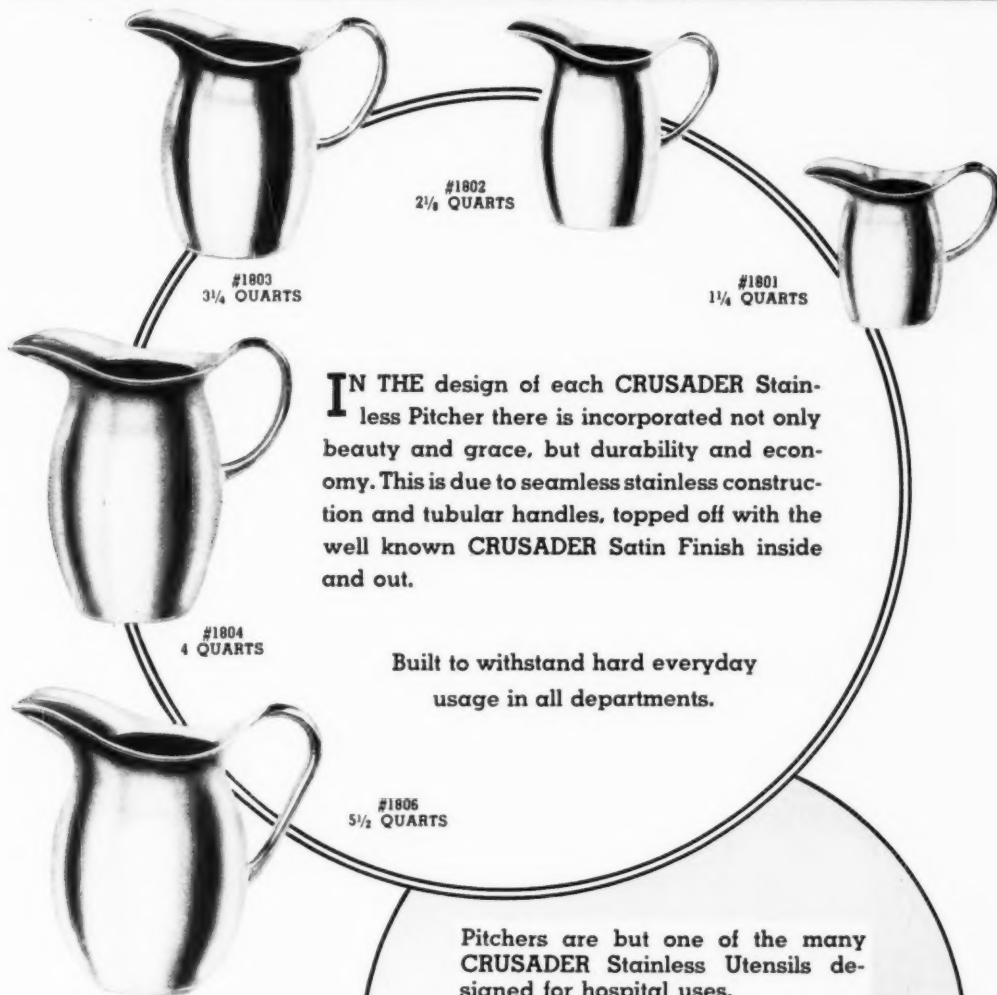
Surveys are now being made in the provinces, Dr. Cameron said, following which the government is "ready to do our share to establish common standards of recruitment, training or any other of the factors which demand such action." Dr. Cameron said one means which would be used to alleviate the nursing shortage would be the establishment of auxiliary staffs with lower educational requirements than professional nursing demands.

Dr. Henry G. Farish, originator of the "point rating system" for hospitals now being used by the American College of Surgeons in its hospital standardization program, described the medical audit as a system of "professional service accounting to determine hospital efficiency."

### Minnesota Alumni Organize

ST. PAUL.—Alumni of the University of Minnesota hospital administration program organized an alumni association, it was announced. Richard Trenker, assistant director of the Charles T. Miller Hospital here, has been elected president. The alumni council is composed of the following members: Arthur Hennings, assistant administrator, Northwestern Hospital, Minneapolis; Telmer O. Peterson, research associate, University of Minnesota course in hospital administration, and John Beckwith, administrative resident, Syracuse Memorial Hospital, Syracuse, N.Y. Robert B. Carey, administrative assistant, Genesee Hospital, Rochester, N.Y., and Franklin Iams, assistant director, Rhode Island General Hospital, Providence, R.I., were appointed secretary-treasurer and editor of the alumni bulletin, respectively.

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## NEWS...

### South Dakota Hospitals Urge Greater Support for Blue Cross-Blue Shield

SIOUX FALLS, S.D.—Action looking toward the promotion of Blue Cross and Blue Shield plans as the most desirable form of voluntary health insurance for South Dakota was taken by the South Dakota Hospital Association at its annual convention here last month. Association members asked their officers to work with the state medical association which is now affiliated with an insurance company program in the development of greater support for the Blue Cross-Blue Shield program.

Officers reelected by the association were: president, O. M. Nelson, Sioux Valley Hospital, Sioux Falls; vice president, Edward M. Graap, St. Luke's Hos-



South Dakota officers (l. to r.) E. M. Graap; E. T. Gough; O. M. Nelson, president; Mrs. Harriet A. Thomas; Sister M. Elizabeth.

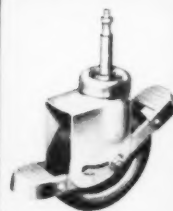
pital, Aberdeen; secretary-treasurer, Harriet Anderson Thomas, Huron; trustees, Rev. Sr. M. Elizabeth, St. John's McNamara Hospital, Rapid City, and E. T. Gough, Methodist State Hospital, Mitchell; house of delegates, Rev. C. M. Austin, Sioux Valley Hospital, Sioux Falls; alternate, Rev. Sr. M. Rose Marie, St. Mary's Hospital, Pierre.

The association unanimously adopted a resolution recommending the government reimbursable cost formula as the basis for payment by state and county welfare departments for indigent patients cared for in voluntary hospitals. The resolution followed presentation of a cost study of 15 hospitals presented by C. M. Austin, administrator of the Sioux Valley Hospital here. The average payment by counties during the first eight months of 1949 was \$6.03 per day, Mr. Austin stated, whereas the cost of caring for these patients averaged \$11.05.

Everett W. Jones, vice president of The Modern Hospital Publishing Company, told a group of Sioux City busi-

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This easy-to-handle Stanley Servitor combines efficient service with durable beauty. Wide mouth makes cleaning easy. Holds 1½ pints palatably hot or cold for hours. Chromium finished in triple plate.



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**COFFEE  
SERVER**  
(Fred Harvey Pattern)



This Fred Harvey pattern is the perfect choice for all hot liquids. By test this graceful server keeps liquids 20 degrees hotter after 2 hours than do ordinary pots. Silver and chrome plated models are available.



**COFFEE  
SERVER**  
(Charter Pattern)



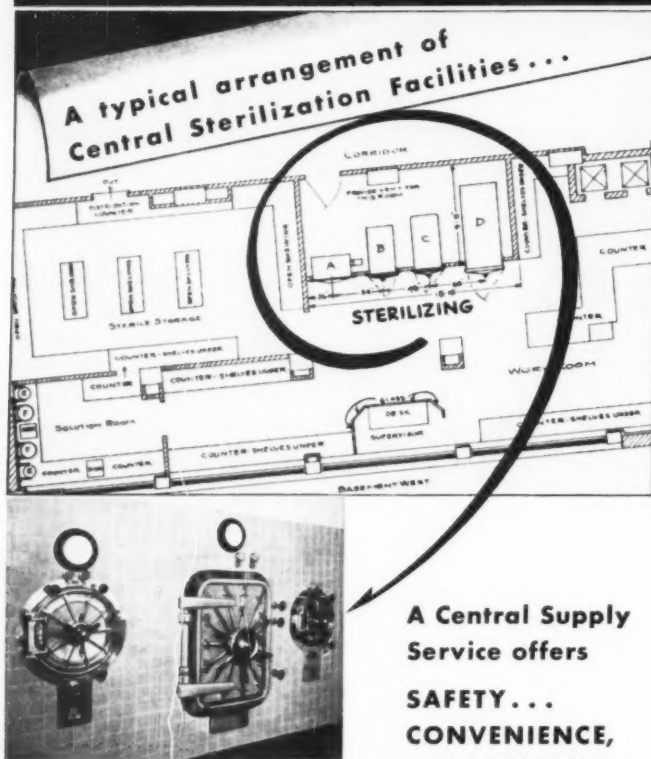
The Charter Pattern insulated coffee server keeps coffee and tea appetizingly hot to the last drop. No wasted steps serving second cup. The patients can help themselves. 10 and 20 oz. sizes available.

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**WRITE:** Wilmot Castle Co., 1175 University Ave., Rochester 7, N.Y.

# Castle

## LIGHTS AND STERILIZERS

## NEWS...

nessmen that construction and operation of a large veterans' hospital at Sioux Falls "didn't make sense." The voluntary hospitals in the area could provide all needed services for veterans more economically, he stated. "If there wasn't sufficient capacity in voluntary hospitals," he added, "beds could have been added much more cheaply at the local hospitals in comparison to the cost of a veterans' hospital. You now have three hospitals here when the two local hospitals could take care of all the veterans."

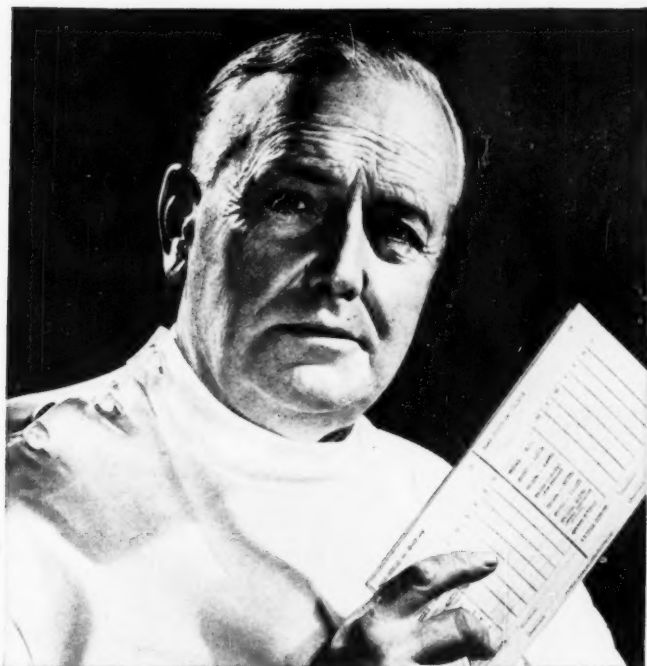
Following Mr. Jones' statement, officials of veterans' organizations disagreed publicly with his views. The veterans' hospital was fully staffed and busy. Howard Carter, service officer for the Veterans of Foreign Wars, replied. "I know from experience from working with the Veterans Administration that they are discouraging unnecessary hospitalization of veterans in government facilities when proper treatment can be taken at home," Mr. Carter said. He also denied that voluntary hospitals could carry the veterans' load. The hospital serves 45 counties in South Dakota, 13 in Minnesota, 10 in Iowa, and eight in Nebraska, he pointed out.

## Washington, Oregon Groups Hold Joint Meeting

PORTLAND, ORE.—Franklin F. Smith, administrator of the Josephine County General Hospital, Grants Pass, Ore., was named president-elect of the Oregon Association of Hospitals at a joint meeting of the Oregon association and the Washington Hospital Association here last month. Mr. Smith was elected to succeed John Sundberg, formerly administrator of The Dalles General Hospital, who has moved to Caldwell, Ida., to become administrator of the Caldwell Memorial Hospital, it was announced.

As successor to Mr. Sundberg, Mr. Smith will take office at the annual meeting of the Oregon Association of Hospitals in May. Speakers at the joint meeting of the two hospital associations were Frank J. Walter, president of the Oregon Association of Hospitals; Dr. Charles T. Dolezal, secretary of the Council on Professional Practice of the American Hospital Association, and Walter A. Heath, administrator of the Tacoma General Hospital, and president of the Washington State Hospital Association.

**Throat Specialists  
report on  
30-Day Test of  
Camel smokers—**



**"Not one single case of throat irritation  
due to smoking Camels!"**

• Yes, these were the findings in a total of 2,470 weekly examinations of hundreds of men and women from coast to coast who smoked only Camels for 30 consecutive days! And the smokers in this test averaged one to two packages of Camels a day!



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*According to a Nationwide survey:*

**More Doctors Smoke Camels  
than any other cigarette!**

Doctors smoke for pleasure, too! When three leading independent research organizations asked 113,597 doctors what cigarette they smoked, the brand named most was Camel!

## NEWS...

### Dr. Bachmeyer Elected President of the Association of American Medical Colleges



A. C. Bachmeyer  
American Medical Colleges at the annual meeting of the association here last

COLORADO month. Dr. Bachmeyer had previously served the association as treasurer.

In an important action affecting hospitals, the association voted to change the intern appointment program which has been in effect for the last two years. The new plan, which will become effective for the intern class of 1951, stipulates that internship applications are to be submitted to medical school deans on the third Tuesday in December. As

soon as the original application has gone forward to the dean's office, it is provided, a duplicate may be forwarded to the hospitals.

Notification day is February 13, under the new plan, but notices of appointment are not to be issued until 8 p.m. on that day, it is specified, in contrast to the midnight "zero hour" which obtained under the previous plan.

Between the December and February dates, the plan provides that medical students may visit the hospitals of their choice and be interviewed by deans and staff members, but no commitments are to be made on either side until 8 p.m. on February 13.

While the revised plan was accepted by association members without extended discussion or debate from the floor, many members expressed the view that the filing of duplicate applications and permissive interviews in advance of the notification date would tend to break down the plan and lead to tacit understandings ahead of formal appointments. However, it was acknowledged, with the number of internships far exceeding the number of interns available each year, no plan could possibly be devised which would guarantee freedom from abuse.

In other significant actions here the association granted full approval to the University of Washington Medical School at Seattle, and to the medical school of the University of South Dakota.

### 70mm FLUORO-RECORD CUT FILM CAMERA



*Chest*  
**Routine X-Rays**

LEADING HEALTH AUTHORITIES suggest routine chest x-rays for all hospital admissions and hospital personnel as a positive aid in detecting and checking the spread of tuberculosis. And leading radiologists endorse the use of inexpensive, easy-to-use 70mm cut film for this purpose because it can be processed immediately after exposure for quick interpretation and is convenient for filing.

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For details see your x-ray equipment supplier or write to Dept. CS, 88-06 Van Wyck Boulevard, Jamaica 1, N. Y.

Other Fairchild precision x-ray equipment includes the new Roll Film Cassette for angiographic studies, 70mm roll film cameras for mass chest x-rays, 70mm cut film and roll film viewers, 70mm film processing equipment, and Chamberlain X-Ray Film Identifier.



### Six Agencies Establish Committee on Health

NEW YORK. — The American Hospital Association joined forces with five other national agencies to form the Inter-Association Committee on Health, it was announced following an organization meeting here last month. The committee will seek to coordinate efforts to improve health care throughout the nation, it was stated.

Also joining the committee were the American Medical Association, American Nurses' Association, American Dental Association, American Public Health Association and American Public Welfare Association.

Raymond M. Hilliard, welfare commissioner for New York State, said the committee would serve as a means for the exchange of information on programs of participating organizations.

	Calories	Protein Gm.	Calcium Gm.	Copper mg.	Iron mg.	Phosphorus Gm.	Vitamin A I. U.	Thiamine mg.	Riboflavin mg.	Niacin mg.	Ascorbic Acid mg.	Vitamin D I. U.
National Research Council Allowances, Sedentary Man (154 lbs.)	2,400	70	1.0	1.2	12	1.5	5,000	1.2	1.8	12	75	Small Amount
Ovaltine in Milk, 3 Servings*	676	32	1.12	0.5	12	0.94	3,000	1.16	2.0	6.8	30	417
Percentages of N. R. C. Allowances Provided by 3 Servings* of Ovaltine in Milk	28%	46%	112%	42%	100%	63%	60%	97%	111%	57%	40%	Abun- dant

\* Each serving made of  $\frac{1}{2}$  oz. of Ovaltine and 8 fl. oz. of whole milk.

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# Ovaltine

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## NEWS...

### Gertrude Sharpe Named President of Vermont Hospital Association

MONTPELIER, VT.—N. Gertrude Sharpe, administrator of the Springfield Hospital at Springfield, Vt., was named president of the Vermont Hospital Association at the association's annual meeting here last month. Miss Sharpe will succeed Godfrey Crosby of Brattleboro who has served as president for the last year.

Other officers named were: vice presi-



Vermont officers (l. to r.): Mary M. Ferry; Godfrey Crosby, past president; Gertrude Sharpe; Charles Capron; Francis Houghton.

dent, Charles W. Capron, Kerbs Memorial Hospital; secretary, Francis Houghton, Rutland Hospital; treasurer, Mary Ferry, Heaton Hospital.

Members of the association heard reports from their delegates to the American Hospital Association convention at Cleveland, from representatives of the Vermont-New Hampshire Blue Cross plan, and from chairmen of committees on A.H.A. affiliations and the Red Cross blood bank program.

Other features of the two-day meeting included panel discussions on public relations and hospital auxiliaries and talks by C. J. Foley, director of public relations for the American Hospital Association, and R. M. Cunningham Jr., managing editor of *The Modern Hospital*.

# 3<sup>1</sup>/<sub>2</sub> times the service with



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### Schmelzer Takes Office as President of Maryland-D.C.-Delaware Association

WILMINGTON, DEL. — National leaders in hospital and health care were featured speakers at the annual conference of the Maryland-District of Columbia-Delaware Hospital Association here last month. Leo Schmelzer, administrator of the Garfield Memorial Hospital at Washington, D.C., took office as president of the association at the conclusion of the conference. Mr. Schmelzer succeeded Benjamin W. Wright, superintendent of the Memorial Hospital at Cumberland, Md., who has served as president for the last year.



Leo Schmelzer

Among those who addressed general sessions of the conference were John N. Hatfield, president of the American Hospital Association, who described the association's program for the coming year; Dr. Basil C. MacLean, director of Strong Memorial Hospital, Rochester, N.Y., who told members of the conference about the regional plan for the provision of health services for rural areas which has been operating for the last two years in the Rochester area, and Dr. Paul R. Hawley, chief executive of the Blue Cross-Blue Shield commission.

Section meetings of the conference were devoted to the special problems of nurse anesthetists, medical technologists, dietitians and other department heads.

# "McCray Koldflos play a big part in helping our new restaurant pay off!"

—says Mr. William Anastos,  
Chicago, Illinois



Ultra-modern design with an Egyptian atmosphere distinguishes the Cairo Restaurant, a favorite with Chicago Cubs from nearby Wrigley Field.

"My brothers and I, in partnership with our uncle, Harry Magafas, built the Cairo Cocktail Lounge and Restaurant when we returned from the war, and I'm happy to say it's paying off as planned.

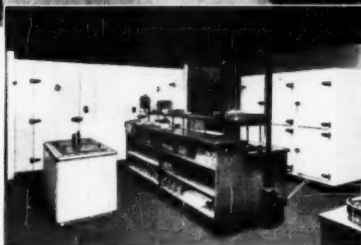
"One big reason for this is efficient kitchen operation, depending to a large extent on our McCray refrigeration. We have a big meat cooler, a short-order box, and a salad box in which we store salads and similar dishes prepared ahead of the rush hour. We can do this safely with the McCray Koldflo system of refrigeration, and it lightens our peak loads of work and does away with worry about spoilage.

"These McCray Koldflos will pay for themselves in short order, for we're convinced they make a very real difference in our operating costs. No wonder we're enthusiastic about McCray!"



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THE BEST IN LOW-COST REFRIGERATION



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**McCray**  
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## NEWS...

### Colby College Holds Extension Course and Clinic on Hospital Problems

WATERVILLE, MAINE—Some 30 hospital administrators throughout the state of Maine registered for the Fifth Extension Course in Hospital Administration held at Colby College here this fall, and sponsored by the Maine Hospital Association. This year's faculty included Ellen G. Creamer, R.N., formerly director of nursing service, New York Post-Graduate Medical School and Hospital, New York; John R. McGibony, M.D., chief, Division of Medical and Hospital Resources, U.S. Public Health Service, Washington, D.C.; Elmina Snow, R.N., administrator, Emerson Hospital, Concord, Mass.; Paul J. Spencer, director, Lowell General Hospital, Lowell, Mass., and vice president, New England Hospital Assembly; Frederick T. Hill, M.D., medical director, Thayer Hospital, Waterville, Maine, past president, Maine Hospital Association, and Mary A. Johnson, coordinator of graduate education, American College of Hospital Administrators, Chicago.

The course was under the direction of Raymond P. Sloan, editor, *The MOD-*

ERN HOSPITAL, assisted by Pearl R. Fisher, administrator, Thayer Hospital, Waterville, Maine.

Hospital administrators and heads of the state departments of health hospital divisions for each of the New England States held a six-day hospital clinic at Colby College, in conjunction with members of the U.S. Public Health Service Boston and Washington offices. Its purpose was, first, to present and discuss problems attendant upon hospital construction in which federal funds, under terms of the Hill-Burton Act, are being used, and, second, to give technical assistance to administrators in equipping their institutions.

Among those participating as speakers and discussion leaders were Dr. John W. Cronin, Washington, D.C., chief, Division of Hospital Facilities, U.S.P.H.S.; Dr. A. Daniel Rubenstein, Boston, hospital programs director, Massachusetts Department of Health; Dr. Brooks Ryder, Boston, representing the Bingham Associates, foundation for betterment of medical care in rural areas of New England; Dr. Frederick T. Hill, Waterville, chairman of the Maine State Hospital Advisory Council and past

president of the American Otolological Society, and Dr. Charles F. Wilinsky, Boston, president of the American Public Health Association.

### N.Y. State Nurses Turn Down Proposal to Make Association Collective Bargaining Agent

BUFFALO, N.Y.—The New York State Nurses' Association at its biennial convention here last month failed to approve a proposal that the association act as collective bargaining agent for its members. After considerable debate, the proposal, which would have carried out the original "economic security" plan of the American Nurses' Association, first proposed two years ago, was set aside when opposition forces said its acceptance would "turn the association into a labor organization."

The association approved a platform calling for federal and state financial aid for nursing education and opposing national compulsory health insurance.

The controversial question of collective bargaining was discussed over a period of two or three days at the convention here. During the final debate, it was reported, bitterness over the issue reached such a high pitch that the board of directors recommended postponement of the decision for another year. The move was opposed by representatives of district associations in the New York City area, following which a compromise solution was reached when the convention settled on a plan calling for an economic security program but omitting the collective bargaining feature.

### Red Cross Accelerates Nursing Service Program

WASHINGTON, D.C.—The American Red Cross has adopted an accelerated program of nursing services designed to meet community needs in home nursing, nurse's aide instruction, disaster nursing, and the over-all enrollment of nurses for volunteer service in the community, it was announced at Red Cross headquarters here last month. The program will include instructor training courses for all home nursing instructors; intensive training of qualified nurses for disaster duty; teaching of nurse's aides to serve both public and private health agencies as well as hospitals, and increasing efforts toward enrollment of nurses to carry on these programs, the announcement said.

# 3 ways

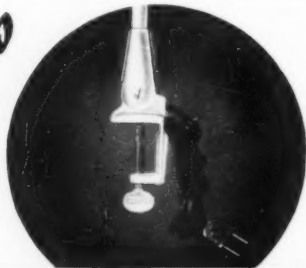
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TRAY CLOTHS



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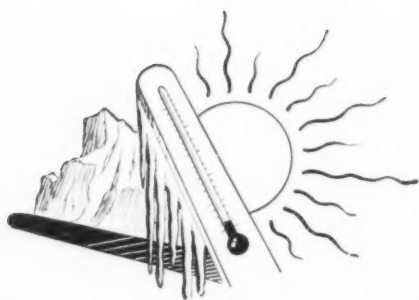
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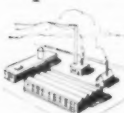


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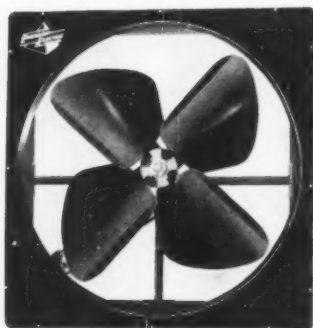


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## NEWS...

### Michigan Hospital Group Holds Three-Day Workshop

GRAND RAPIDS, MICH.—More than 200 delegates who attended the 30th annual meeting of the Michigan Hospital Association here last month declared the workshop program to be one of the best in the history of the organization. President Ronald Yaw, director of Blodgett Memorial Hospital, set up a series of rapid-fire short talks and discussions on what the hospital expected from trustees and various departments of the hospital. In return, the trustees, medical board, nurses and others stated what they expected from the hospital.

Back of all the talks and the discussions that followed was the thought that there was still a great need for all—the public, the trustees, the staff, nurses and others—to know more about the policies of the hospital and the work it was attempting to do in the community.

President John Hatfield of the American Hospital Association and President Wilmar Allen of the American College of Hospital Administrators addressed the convention and were active in the discussions.

Mr. Yaw turned the gavel over to the new president, E. Dwight Barnett, Harper Hospital, Detroit. Other new officers are: president-elect, B. D. Dann, superintendent of Hackley Hospital, Muskegon; first vice president, Lauretta Paul, director of Pontiac General Hospital; second vice president, Ralph Hutchins, superintendent of Central Michigan Community Hospital, Mt. Pleasant; treasurer, Glen W. Fauser, director, Edward W. Sparrow Hospital, Lansing, and Allan Barth, secretary of the Michigan Hospital Association.

The Woman's Hospital Auxiliary met at the same time; 90 members were in attendance. The house of delegates of the Michigan Hospital Association amended its by-laws so that the auxiliary was taken into its membership on the state level as the A.H.A. has done with the National Association of Women's Hospital Auxiliaries.

### Start \$700,000 Addition

EAU CLAIRE, WIS.—Construction of a \$700,000 addition to the Luther Hospital here was undertaken last month. Plans call for a 61 bed addition to the present hospital plant which has been seriously overcrowded, it was reported.



Shown above: Simmons Hospital Room No. 71. Color Scheme No. 7201 Dusty Rose with Shell. Self-Adjusting Bed, H-517-L-195; Dresser Base, F-180-3, with Mirror FM-62; Bedside Cabinets, F-480-F; Arm Chair, F-763; Chair, F-711; Footstool, F-909-R; Single Pedestal Overbed Table F-882.



This cleverly designed overbed table can be lowered to 29 $\frac{1}{2}$  inches for use by patient in chair. Maximum height of overbed table is 44 $\frac{1}{2}$  inches. Double hinged top permits use from either side of bed. Easily removed inset tray provides space for toilet articles, writing materials and other patient necessities. Order No. F-882.

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The bed is Simmons famed Self-Adjusting Model that helps patients help themselves. The ingenious overbed table serves as table, book rest and vanity! The new Simfast finish in Dusty Rose with Shell resists damage from spilled liquids, medicine, heat and cold.

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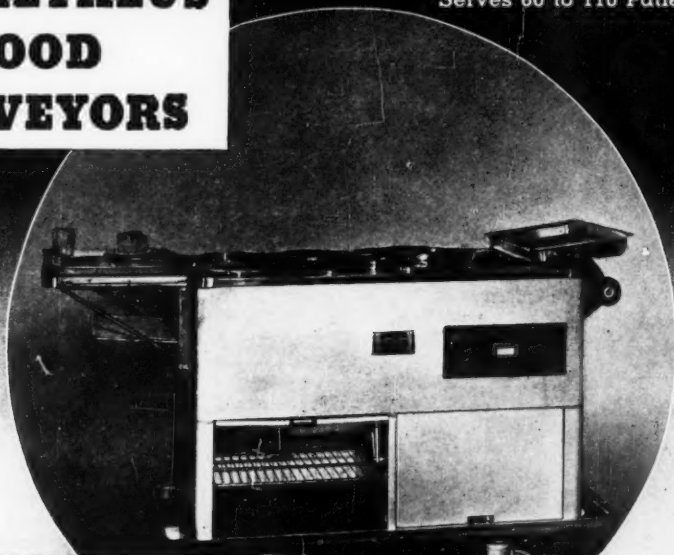
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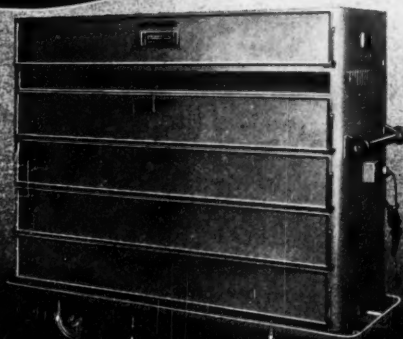
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## NEWS...

### Cooperative Health Plans Cover Approximately 3,000,000, A.P.H.A. Told

NEW YORK.—A report on the operation of consumer-sponsored group health plans featured the annual meeting of the American Public Health Association here last month. Jerry Voorhis, executive secretary of the Cooperative Health Federation of America, said that the membership of plans affiliated with the federation now totals more than 400,000 families and that all group

health cooperatives probably included as many as 3,000,000 persons now "receiving a major portion of their medical care through such plans."

The plans include large urban cooperative health associations, hospitals and health centers operated by co-ops in rural areas, prepayment plans through which arrangements are made for care of members by panels of physicians, and group health insurance companies providing cash indemnity coverage for members of such groups as labor unions,

farm cooperatives, credit unions and similar organizations, Mr. Voorhis said.

Named as obstacles to the growth of the consumer-sponsored plan were lack of trained organizers and administrators, restrictive legislation and discriminatory practices against doctors participating in such plans by a few state and local medical societies. Mr. Voorhis expressed the hope that approval by the house of delegates of the American Medical Association of its standards for group health organizations would put an end to such discriminatory practices.

In other meetings, members of the association heard descriptions of the British National Health Service in operation and discussed the British plan with a panel of representatives from Britain and the United States. "No one is more conscious than the British people are of the defects in this new service," Prof. Leslie Banks of Cambridge University told the meeting, "but the fact remains that it has worked without breakdown throughout this first year. Alterations and improvements will result in the final product resembling our present effort as little as the modern jet aircraft resembles the original machine flown by the Wright brothers."

Dr. J. T. Rice-Edwards of the British Medical Association deplored the introduction of a third party—the Minister of Health—into the doctor-patient relationship in Britain. "In the passing of medical practice from private to public ownership, the patient has lost a good guarantee of service and direct contact with his doctor," Dr. Rice-Edwards stated.

Dr. Charles F. Wilinsky, administrator of Boston's Beth Israel Hospital, retiring president of the association, addressed the annual banquet on the subject "the public health of tomorrow." Dr. Wilinsky said that fewer than 30,000 men and women are engaged in public health work whereas at least 60,000 were needed to maintain existing services on an adequate basis and that many more would be required to cover areas not now properly served.

### Nursing Enrollment Up

NEW YORK — Increased enrollment in nursing schools here compared to recent years was reported last month by Ethel G. Prince, executive secretary of the nurses' associations of several counties in the metropolitan area.

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## NEWS...

### Administration Sponsors Doubt Passage of Health Legislation in 1950

WASHINGTON, D.C.—Sponsors of the administration's compulsory health insurance program have abandoned hope for passage of the legislation by Congress in 1950, the Washington bureau of the *New York Times* reported here last month. Administrative strategy calls instead for an investigation aimed at developing a more acceptable health bill, it was reported.

After Congress reconvenes next January, it is likely that Mr. Truman will renew his demands for a compulsory prepayment plan financed by pay roll taxes, the *Times* bureau said, but it is unlikely that the President's supporters will press for a decision on the floor of Congress until 1951 at the earliest, it was pointed out.

As an indication of fading support for the administration's plan next year, Senator Humphrey of Minnesota, previously a leading proponent of compulsory health insurance, stated last month, "until the practical difficulties of administering the disputed plan have been met, legislative action might be a disservice to the principle in which we believe." Senator Humphrey recommended that Congress defer action on the plan "pending further study and until enactment of related health measures."

### Municipal Hospitals Raise Wages of Nursing Staff

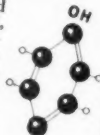
CHICAGO.—The finance committee of the city council approved pay increases for city nurses at the Municipal Contagious Disease Hospital and Municipal Tuberculosis Sanitarium here last month following public hearings on the budget at which Dr. Herman N. Bundesen, president of the board of health, stated that lack of nurses was forcing the hospital to turn away patients desperately needing hospital care. A number of babies died during the year for lack of hospital facilities, Dr. Bundesen charged. The Contagious Disease Hospital had fewer than 20 nurses on its staff because of the low wages paid there, Dr. Bundesen said, although there was need for as many as 40 nurses to provide adequate care.

The budget called for increases of \$25.50 a month for nurses on the two hospital staffs.

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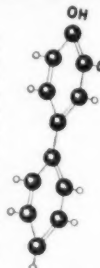
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## NEWS...

### Lucile Petry Appointed to W.H.O. Nursing Committee

WASHINGTON, D.C.—Lucile Petry, assistant surgeon general and chief nurse of the Public Health Service, has been appointed to the Expert Committee on Nursing of the World Health Organization, it was announced here last month. The committee will hold its first meeting in Geneva, Switzerland, Feb. 20 to 26, 1950. Miss Petry attended the first World Health Assembly in Geneva in June 1948 and was the

only nurse among representatives of 52 participating nations.

"The appointment is a tribute not only to Miss Petry as an individual, but to the accomplishments of the nursing profession in the United States," Surgeon General Leonard A. Scheele stated. "There has been growing recognition everywhere of the fundamental importance of nursing in the improvement of health services and of the function of the nurse as an active partner in the health team. Without the nurse, med-

ical and public health programs cannot be carried to completion. Therefore, the problems of recruitment and of training for complex nursing tasks are worthy of consideration by a special committee."

### Discuss Hospital Problems at Two-Day Conference

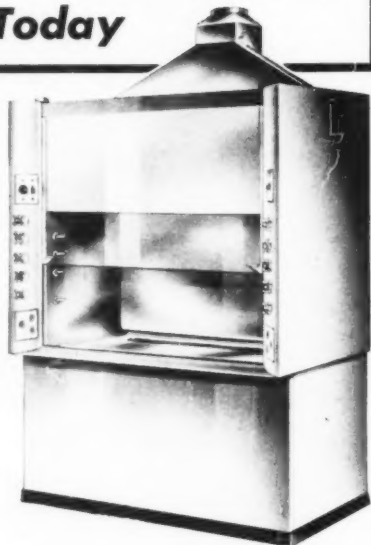
CLARKSBURG, W.VA. — Members of the Hospital Association of West Virginia met with other public and private health and welfare agencies in a two-day conference here last month to discuss various problems associated with the financing of hospital care and the operation of hospitals.

The meeting was held under the sponsorship of the hospital association, it was reported. Members of all attending groups voted at its conclusion to make the conference an annual affair. More than 125 persons attended the conference, which represented state and local public health representatives, welfare officers and representatives of nursing, union, Blue Cross, compensation and insurance groups.

Topics discussed during the conference were public health and construction, nursing, insurance and hospital service plans, it was reported.

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### COMING MEETINGS

AMERICAN HOSPITAL ASSOCIATION, Mid-Year Conference of Presidents and Secretaries, Drake Hotel, Chicago, Feb. 10, 11.

AMERICAN PROTESTANT HOSPITAL ASSOCIATION, Congress Hotel, Chicago, March 1-3.

ASSOCIATION OF WESTERN HOSPITALS, Olympic Hotel, Seattle, April 24-27.

BOARD OF METHODIST HOSPITALS AND HOMES, Congress Hotel, Chicago, March 1, 2.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Frances Marion Hotel, Charleston, S.C., May 11, 12.

IOWA HOSPITAL ASSOCIATION, Hotel Savery, Des Moines, April 21.

KENTUCKY HOSPITAL ASSOCIATION, Kentucky Hotel, Louisville, March 28-30.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Memorial Auditorium and Convention Hall, Buffalo, N.Y., May 24-26.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, April 12-14.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 27-29.

OHIO HOSPITAL ASSOCIATION, Neil House, Columbus, March 22-24.

SOUTHEASTERN HOSPITAL CONFERENCE, Vinoy Park Hotel, St. Petersburg, Fla., April 5-7.

TEXAS HOSPITAL ASSOCIATION, Buccaneer Hotel, Galveston, March 7-9.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-4.



## How to have one less administrative headache



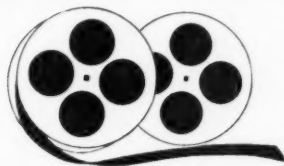
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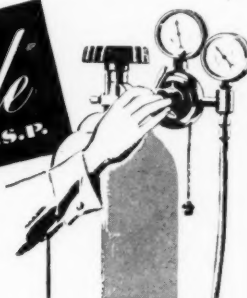
**MEDICAL INFORMATION:** OXYGEN THERAPY NEWS; Medical Reprints; and "Bibliography on Oxygen Therapy."




**TECHNICAL INFORMATION:** "Oxygen Therapy Handbook"; OXYGEN THERAPY BULLETIN; Case Charts; Cylinder Flow-Chart Tags; Cylinder Contents Tags; Caution Signs; and Nursing Procedures.



**MOTION PICTURES:** "Oxygen Therapy Procedures"; "Physiology of Anoxia"; "Oxygen Therapy in Heart Disease."



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## NEWS...

### Amendments to P.L. 725 Will Lead to Better Service to Hospitals, Scheele Says

WASHINGTON, D.C.—Important research leading to improved services in existing hospitals was made possible by the amendments to the Hospital Survey and Construction Act which were passed last month, Public Health Service officials said here. The amendments also doubled the amount of federal funds which will be made available to the states and liberalized the amount of the federal contributions, it was explained.

"We are particularly gratified that the Congress has authorized funds for research in the improvement of hospital services," said Surgeon General Leonard A. Scheele. In discussing the research program authorized under the amendments, Dr. Scheele emphasized that one important aspect of the planning will be to provide better linkage between large urban hospital centers and hospitals in smaller areas. "Careful planning," he said, "can go a long way toward avoiding wasteful duplication in new construction. Smaller hospitals too frequently are forced to operate as isolated units. For example, they cannot afford large outlays for the high-priced equipment which is maintained in larger medical centers. It is our hope to work out a means by which specialized types of service now found only in larger hospitals will be available to smaller units."

Pioneer projects in such interhospital relationships are already being conducted at the Medical College of Virginia, the New England Medical Center, operating out of Boston, the Council of Rochester Regional Hospitals, Rochester, N.Y., and at the medical school of the University of Michigan. These projects, it is anticipated, will continue to serve as useful sources for data on professional and administrative problems, as well as such matters as appropriate patient loads and such highly complex operations as the maintenance of diet kitchens, the operation of laundries, and other hospital services.

Under the provisions of the amendments, Dr. Scheele pointed out, the Public Health Service is authorized to make grants for additional studies to the states, medical schools, regional hospital councils, and similar private, non-profit institutions in an expanded research program. These studies, he said, may include such projects as the estab-

lishment of rotating internships, refresher courses for physicians, clinical conferences and provisions for common use of diagnostic facilities and equipment, all of which will be of aid to smaller hospitals.

### U.S.P.H.S. Starts School for Medical Record Librarians

WASHINGTON, D.C.—A school for medical record library training in the federal services has been established by the Division of Hospitals of the U.S. Public Health Service, it was announced here last month. This training course is approved by the Council on Medical Education and Hospitals of the American Medical Association, the announcement said.

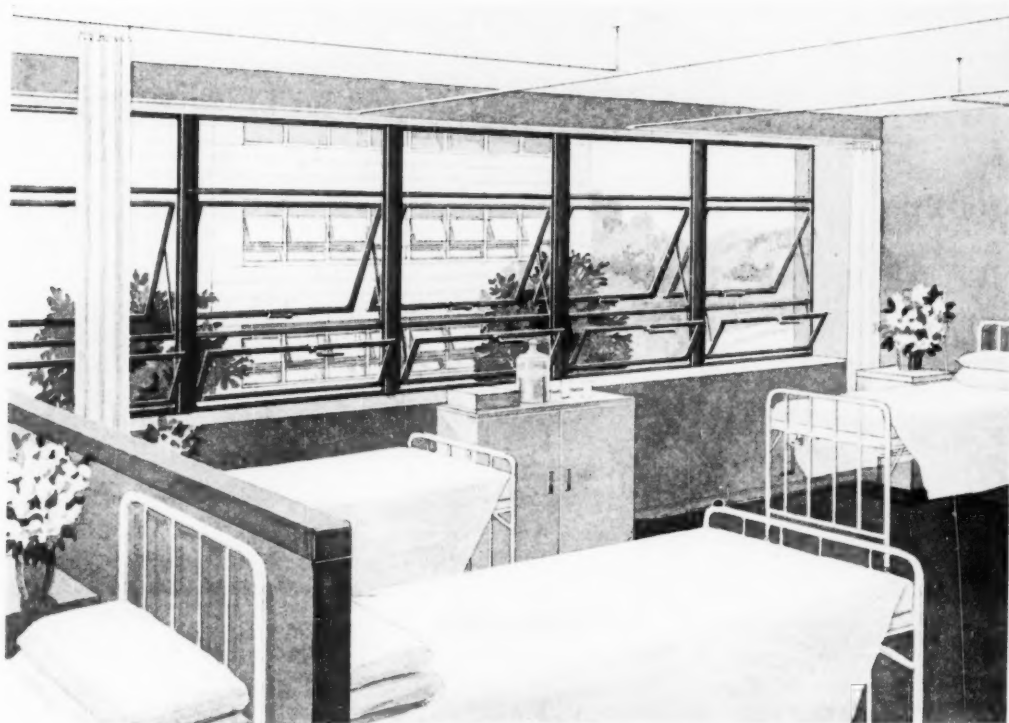
The course includes two years of instruction in the Baltimore Junior College and a year of specialized training in the U.S. Marine Hospital at Baltimore, it was explained. Graduates may be given an opportunity to remain in the Public Health Service, but are not obligated to do so.

Instruction is under the direction of Loyola Voelker, formerly instructor in the school for medical record librarians at the College of St. Scholastica and St. Mary's Hospital, Duluth, Minn.

### New Duties Assigned to Federal Hospital Council

WASHINGTON, D.C.—New duties assigned to the Federal Hospital Council as a result of the amendments to Public Law 725 received attention at a council meeting last month. Latest responsibilities of the council include programs of research and demonstrations related to hospital services and the coordination of hospitals, it was explained. The council is authorized to consult with the Public Health Service in making grants to regional hospital councils, universities, hospitals and other public and nonprofit agencies for conducting research and demonstrations in the effective development, coordination and use of hospitals and related services.

New members appointed to the council by the Federal Security Administrator are: Jonathan Daniels, editor of the *News and Observer*, Raleigh, N.C.; Rev. Donald A. McGowan, National Catholic Welfare Council, Washington, D.C.; and Dr. Anthony J. J. Rourke, superintendent of the Stanford University Hospitals, San Francisco.



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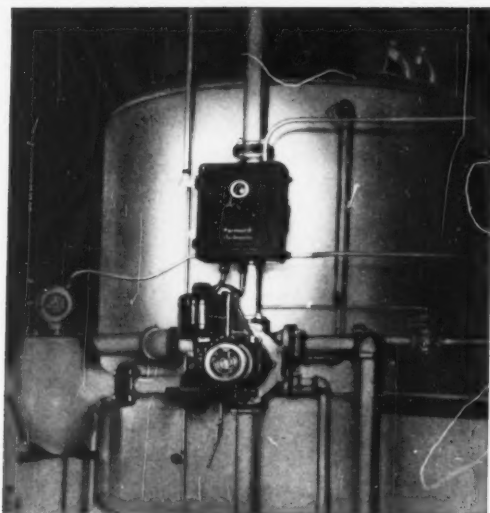
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**NEWS...**

**Plan New Building  
for New York Infirmary**

NEW YORK.—Construction of a new \$4,000,000 hospital for the New York Infirmary is expected to start some time in 1950, it was announced here last month. Skidmore, Owings and Merrill are the architects.

The plans call for an 11 story, 215 bed structure on the present hospital



Architect's model of New York infirmary.

site here, the announcement said. The new infirmary will replace the cramped and antiquated quarters of the old infirmary, improvised by the joining of five old buildings, it was explained. Present capacity of the infirmary is 121 beds.

**Shorten Medical Education,  
Yale Dean Recommends**

NEW HAVEN, CONN.—Medical education can be shortened without sacrificing standards, Dr. C. N. Hugh Long, dean of Yale University's school of medicine, stated in his annual report to the university published here last month. Dr. Long recommended that medical students be permitted to commence their studies at an earlier age so that they would not have to wait until they are 28 or 30 years old before starting practice.

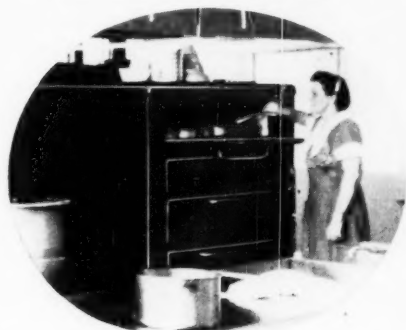
Dr. Long also stated that medical education would have to adjust itself to the growing public feeling that all people are entitled to adequate medical care regardless of economic circumstances. He also suggested that medical schools would have to accept government aid in order to survive without "catastrophic reduction of educational standards."

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## NEWS...

### Survey Shows New England Fund Campaigns Raised \$66,767,781 for 83 Hospitals

CAMBRIDGE, MASS. — Eighty-three New England hospitals conducted 99 separate fund-raising campaigns during the period 1941 to 1949, a survey made by Dr. A. G. Engelbach, director of Mount Auburn Hospital here, revealed. The survey, which was reported by Dr. Engelbach last month, covered 180 hospitals in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and

Vermont. One hundred and fifty-nine hospitals ranging in size from 25 to more than 800 beds replied to the inquiry, Dr. Engelbach said. Summarizing the results, Dr. Engelbach reported that an aggregate of \$66,767,781 was subscribed in the 99 campaigns reported. This was 91 per cent of the \$74,000,000 aggregate goal for the campaigns, he said. Of the total amount subscribed, approximately 76 per cent had actually been collected at the time the survey was made, it was indicated. However,

Dr. Engelbach pointed out many of the pledges made during the various campaigns were obviously still in process of being collected.

The majority of the campaigns were conducted in the postwar years, the survey indicated. Thirteen were held in the first half of 1949; 48, in 1948; 18, in 1947, and 14, in 1946, the survey revealed. The other campaigns figuring in the summary were conducted during the war years, the report showed.

Commenting on the \$66,000,000 pledge to the support of New England hospitals in this period, Dr. Engelbach said: "The total makes a considerable imprint of the Yankee desire to be independent and provide themselves with necessities."

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### Laundry Management Course To Be Offered at U. of Iowa

IOWA CITY, IOWA—A training course in hospital laundry management will be offered by the American Hospital Association and the extension division of the State University of Iowa here February 13 to April 7, 1950, it was announced last month. Special courses in laundry chemistry, textiles, personnel management, record keeping and accounting, hospital organization and relations, engineering background, speech and note taking and report writing will be offered during the eight-week period, the announcement said.

### New York City Voters Approve Bond Issue

NEW YORK.—Approval of the \$150,000,000 city bond issue for financing rehabilitation and expansion of the municipal hospital system was given overwhelmingly by voters throughout the state last month. With most precincts counted, the statewide totals were 1,353,985 in favor of the bond issue and 558,260 against.

Within the five boroughs of New York City the total vote was 961,474 in favor and 165,723 against.

Norman Goetz, president of the Hospital Council of Greater New York, said the expansion program was a "flexible long-range plan geared to community requirements." The total program will ultimately provide 2600 additional hospital beds along with needed rehabilitation of existing facilities, it was stated.

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\*Or by costly modifications. See F.C.C. Rules and Regulations, Title 47—Part 150.

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## NEWS...

### Dr. Clark Takes Over as Head of Massachusetts General

BOSTON.—Medical care prepayment plans covering only surgical and obstetrical fees do not answer the public need, Dr. Dean A. Clark stated here recently. Dr. Clark was interviewed by newspaper reporters as he took over directorship of the Massachusetts General Hospital. Dr. Clark succeeded Dr. Nathaniel W. Faxon who has retired.

For every surgical operation or delivery paid for by medical plans in 1948, there were nearly 60 medical treatments of other than surgical or obstetrical nature, Dr. Clark said. "Also," he added, "for every medical service rendered in the hospital there were 12 rendered outside the hospital. Under the limited insurance plans there is quite an incentive for the patient to go to the hospital."

Many problems in connection with the distribution of medical service have not yet been met, Dr. Clark told the press conference. The problem, he explained, is that a self-supporting, comprehensive medical plan would be too expensive for the people who need it most.

Francis C. Gray, chairman of the hospital's board of trustees, said that Dr. Clark would be known as "general director" of the hospital and relieved of routine administrative duties so that he might devote himself to the greatest possible extent to larger aspects of the hospital's rightful place in the community.

"The functions of hospitals have changed," Dr. Clark said, "but hospitals have not yet caught up with what they should be doing." He mentioned the location of public health centers in hospitals, the development of home care programs, and organization of group diagnostic services as possible avenues of future development.

### Course in Hospital Design

NEW HAVEN, CONN.—A special course in hospital design problems was conducted at the school of architecture here over a period of several weeks in September, October and November. The course was made possible by a contribution from Charles Neergaard, New York hospital consultant, Alfred Aydelott of the firm of Dent & Aydelott, Memphis, Tenn., directed the program in which a number of nationally known hospital design authorities also participated.

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## NEWS...

### Fire Department Disapproves of Oxygen Piping System at Columbia-Presbyterian

NEW YORK. — The oxygen piping system recently installed at Columbia-Presbyterian Medical Center has been disapproved by the city fire department, it became known last month. The medical center installation cost more than \$35,000 and comprises a network of piping totaling three miles, it was reported. More than 300 of 600 wall outlets are already installed in units of

the medical center and the remainder were scheduled for completion within a few months, the report said.

Hospital officials stated that the system was planned for eventual extension to the entire Columbia-Presbyterian Hospital group of 1500 beds.

Fire department rejection was based on the contention that insufficient safeguards had been proposed, it was learned. The fire department held that the 2400 pounds' pressure under which oxygen was to be stored in trailers in

a parking lot adjoining the hospital grounds exceeded the limits of safety.

Engineering consultants for the hospital and manufacturers of the equipment used in the installation stated that recommendations of the National Fire Protection Association had been followed and described the system as safe.

The fire department said that St. Luke's Hospital here had also been notified that its oxygen system should be discontinued.

Dr. Marcus Kogel, commissioner of hospitals for the city, said that central oxygen piping systems were planned for all new hospitals to be constructed by the department. Piping oxygen directly to the patient's bedside was a great advance over old methods, Dr. Kogel said, and small installations were planned for hospitals now under construction. Dr. Kogel expressed confidence that all fire violations in the existing oxygen piping systems could be corrected.

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### Open Children's Ward in I.N.I. Neurology Unit

CHICAGO. — A children's ward in the neurological service has been opened at the Illinois Neuropsychiatric Institute here, the University of Illinois announced last month. The new facilities have been designed to accommodate three infants and nine children under 12 years of age, the announcement said.

Facilities now available on the floor include an examination room, convalescent ward, nursery and three isolation rooms. The new ward will be under the supervision of Dr. Eric Oldberg, professor of neurology and neurological surgery and head of the department at the University of Illinois College of Medicine.

### Merges With N.Y.U.-Bellevue

NEW YORK.—The Struyvesant Square Hospital, formerly the New York Skin and Cancer Hospital, has united with the New York University-Bellevue Medical Center, it was announced following a conference here last month in the offices of Chancellor Harry Woodburn Chase of New York University. Completion of the necessary legal arrangements effecting the merger will be subject to approval by appropriate state agencies and courts, the announcement said.

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## NEWS...

### Eight Illinois Hospitals Drop Affiliation With St. Louis Blue Cross

MOUNT VERNON, ILL.—At a district meeting of the Illinois Hospital Association here last month, eight southeastern Illinois hospitals voted to discontinue affiliation with the St. Louis Blue Cross plan. The action resulted from a long standing dispute over whether hospitals in the southern Illinois area should affiliate with Blue Cross plans in St. Louis or Chicago, it was explained.

Hospitals here claim that they have lost money during their affiliation with the St. Louis plan, it was reported.

Hospitals which have discontinued their contracts with St. Louis Blue Cross are the Jefferson Memorial Hospital here; St. Joseph's Hospital at Breese; St. Mary's and Christian Welfare Hospitals at East St. Louis; St. Mary's, Centralia; St. Clement's, Red Bud; Herrin Hospital at Herrin, and Salem Memorial at Salem.

### N.Y. Blue Cross Lowers Minimum Group Enrollment

NEW YORK.—A new regulation, effective immediately, lowers from five to four persons the minimum number required for group enrollment in the Blue Cross and Blue Shield plans here, according to a statement issued last month by Associated Hospital Service and United Medical Service. The new regulation conforms to the provisions of the New York State disability benefits law and affects not only employees of small business organizations who may wish to enroll on a group basis but many of those already enrolled on a nongroup basis, it was explained. As group members the latter will be entitled to maternity benefits and lower subscription costs.

### Oklahoma Group Meets

TULSA, OKLA.—Major problems of hospital administration were discussed in general and special sessions of the Oklahoma State Hospital Association convention here last month. Subjects scheduled for discussion include special problems of the small hospital, Blue Cross hospital relations, legal aspects of hospital operation including obligations of public agencies for care of indigent patients, public and personnel relations, purchasing and accounting.



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## ABOUT PEOPLE

(Continued from Page 78.)

Anna Cressman will become acting assistant chief under Miss Hughes.

**Dr. Philip Willner** has been appointed chief orthopedist at Doctors Hospital, Newark, N.J. He is orthopedic surgeon of the Newark Department of Health, and acting associate chief of orthopedics at Newark City Hospital.

**Anna E. Ryle**, assistant director of nursing at Grace-New Haven Hospital,

New Haven, Conn., since 1943, has been appointed director of nursing service and of the Westchester School of Nursing, Grasslands Hospital, Valhalla, N.Y. Miss Ryle succeeds **Mrs. Almira Hemstead Ockerman**.

### Miscellaneous

**Dr. Bowman C. Crowell** has retired as associate director and director of clinical research of the American College of Surgeons, with which he had been connected since 1926. Dr. Crowell recently was awarded the American Cancer Society's first annual medal "in recogni-

tion of his outstanding contributions to the control of cancer."

**Dr. Malcolm T. MacEachern**, associate director of the American College of Surgeons since 1923, has been appointed director. Dr. MacEachern, chairman of the administrative board of the college since 1935, is also professor of hospital administration at Northwestern University, director of the program in hospital administration since 1943, and director of the Chicago institute for hospital administrators of the American College of Hospital Administrators. He was named president elect of the American Protestant Hospital Association at the convention in Cleveland this fall.

Dr. MacEachern is the third director in the history of the American College of Surgeons.

**Laurence P. Johnston, A.I.A.**, has moved his offices from Evanston, Ill., to 4105 Wisconsin Ave., N.W., Washington, D.C. For the last year Mr. Johnston has worked in association with Foss and Malcolm, architects of Juneau, Alaska, in planning the 400 bed Anchorage hospital for the Alaska Native Service.

**Gertrude Stier**, director of Mercy Hospital School of Nursing, Urbana, Ill., has been appointed chairman of the Illinois State Board of Nurse Examiners. She succeeds **Sister Mary Therese**, formerly of Mercy Hospital, Chicago, who is now serving on the faculty of Catholic University, Washington, D.C.

**Dr. James L. Troupin** has been appointed associate professor of public health practice, School of Public Health, Columbia University.

### Deaths

**Charlotte M. Dunning**, 76, superintendent of nurses at Doctors Hospital, New York City, from its founding in 1930 until her retirement in 1942, died November 1 after a long illness.

**Sir Herbert Eason**, president of Britain's General Medical Council, died November 3 in London at the age of 75 years.

**Lena North**, who owned and operated North's Hospital Registry in Louisville, Ky., for many years, died recently in Yazoo City, Miss.

**Dr. P. S. Tate**, assistant superintendent of the State Hospital at Fulton, Mo., died November 11 from injuries received in an automobile accident. He was 71 years old.



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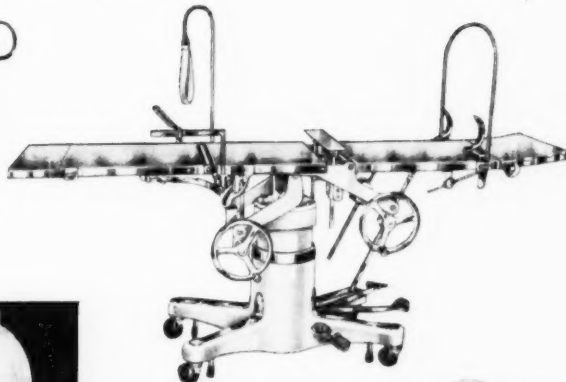


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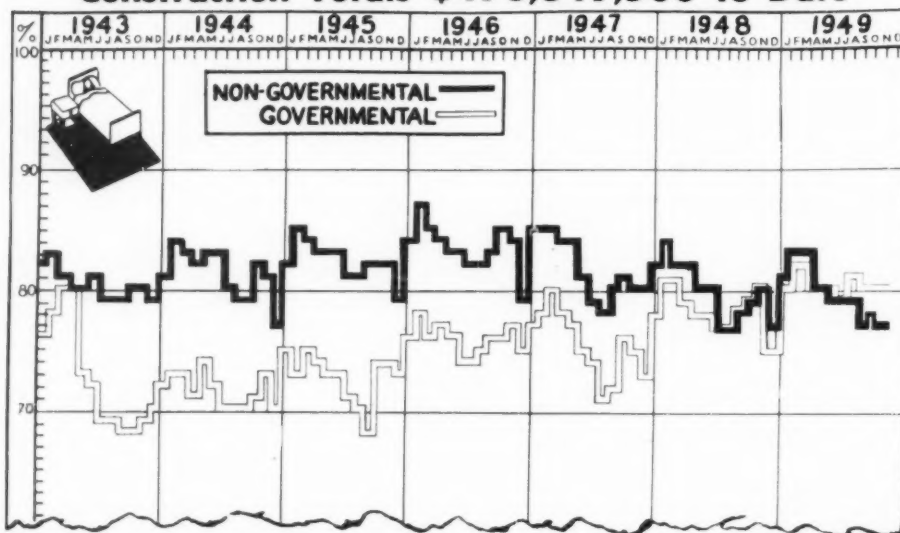
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## Construction Totals \$478,849,500 to Date



At 77 per cent of capacity, occupancy of nongovernmental hospitals reporting to the Occupancy Chart for the month of October was somewhat lower than the figure for October a year ago. Government hospitals, on the other hand,

were up a little, at 80 per cent, from occupancy in 1948.

Hospital construction reported for the latest period totaled \$37,848,045, bringing the total reported for the year to date up to \$478,849,500. Of 29

projects reported recently, 12 were new hospitals costing \$8,496,506, and 16 were additions to existing institutions, costing \$11,086,539. The remaining project was a remodeling job reported at \$235,000.

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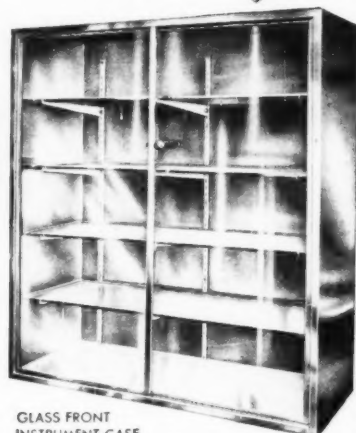
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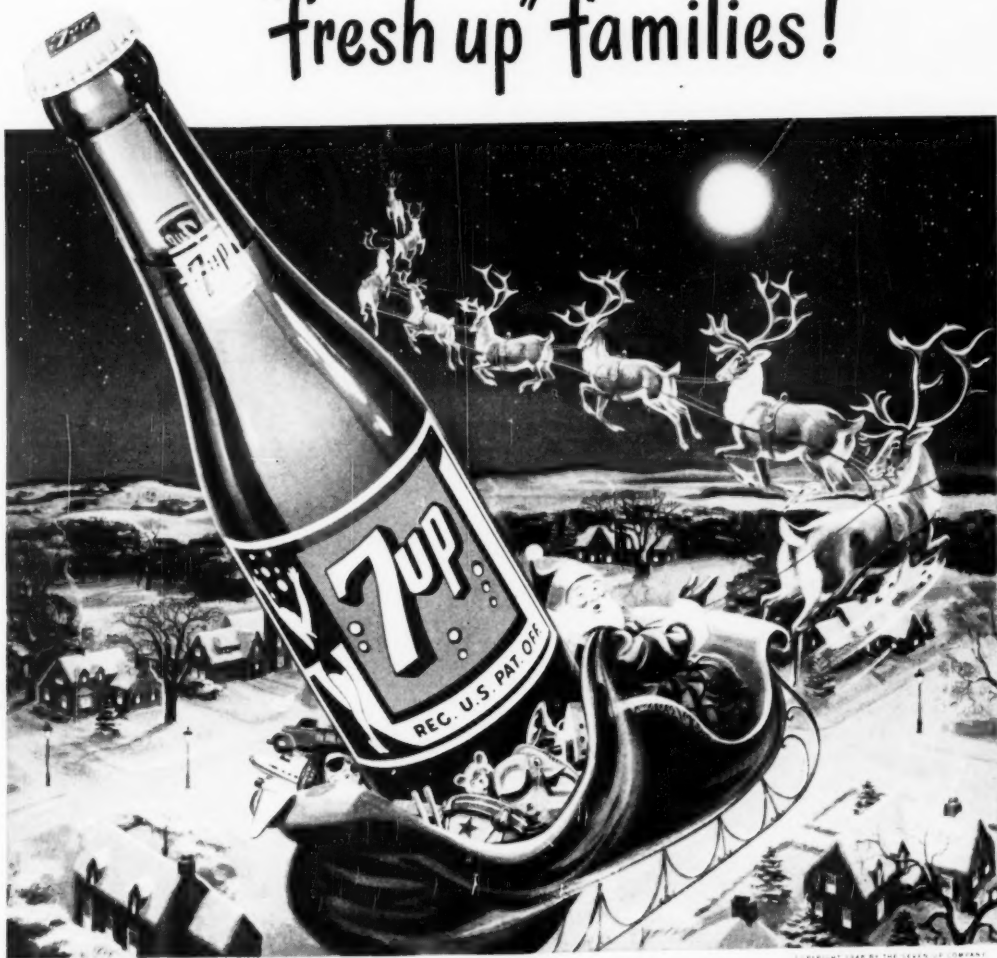
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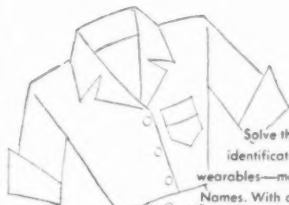
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# Canned Foods as a Source of Niacin

(NICOTINIC ACID)

No. 5 in a series which summarizes the conclusion about  
canned foods reached by authorities in nutrition research

Niacin is that member of the vitamin B complex which was formerly known as the "pellagra-preventive" or "P-P" factor. It is a normal constituent of all cells and functions as a component of enzymes in both glycolysis and respiration. (1)

Deficiency of niacin manifests itself in skin lesions, inflammation of mucous membranes, and when extreme, leads to symptoms of florid pellagra. Typical pellagra, however, may be the result of a multiple nutritional deficiency and is treated by the administration of not only niacin, but other members of the vitamin B complex, particularly riboflavin and thiamin. (2)

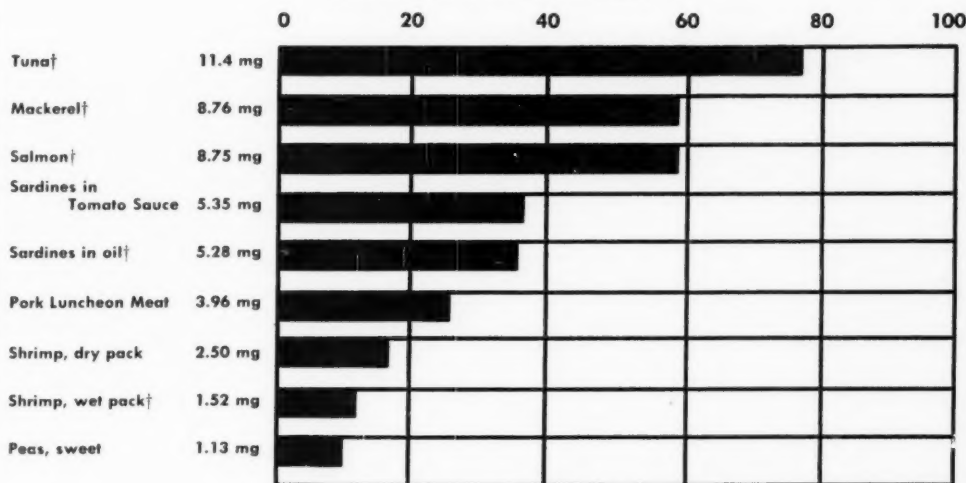
A diet rich in proteins containing tryptophane, which is believed to be a precursor of niacin, is usually recommended. (3)

Meat, fish, cereal and legumes are the best sources of niacin. These foods contain the nutrient in relatively large amounts and the daily allowance can be obtained from a serving of several of them.

Niacin is heat stable so there is a good retention of the nutrient during the canning process. A number of commercially canned foods, in particular canned fish, meat, and legumes are important sources of niacin. (4)

## Percentage of Recommended Daily Allowance\* in 4-oz. (113 grams) Serving (4)

(Based on analysis of the entire can contents)



†Brine or oil discarded.

\*Percentage based on recommended daily allowance for physically active male—15 mg.—National Research Council.

(1) 1943. *Handbook of Nutrition*. A. M. A. Council on Foods and Nutrition. Page 220. American Medical Association, Chicago.

(2) 1945. *Chemistry and Physiology of the Vitamins*.

H. R. Rosenberg. Page 246. Interscience, New York.

(3) *Proc. Soc. Exp. Biol. Med.* **70**, 569-571 (1949).

(4) 1947. *The Canned Food Reference Manual*. American Can Company. Adapted from pages 251-252. New York.



AMERICAN CAN COMPANY • 230 Park Avenue, New York 17, New York



The Seal of Acceptance denotes that this advertisement has been reviewed by the Council on Foods and Nutrition of the American Medical Association and has been accepted by them.



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soaps and synthetics  
than anybody!

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# Want Advertisements

## POSITIONS WANTED

**ADMINISTRATOR**—Assistant, or **PURCHASING AGENT**—With many years of successful business experience in purchasing, personnel management, public relations and research; this 50 year old man wants to join the administrative staff of some hospital; married; B.S. Degree. MW 74, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**ADMINISTRATOR**—Experienced; excellent executive; two degrees; knows medical as well as business phase of modern hospital management including construction, equipment, purchasing and personnel; free to locate anywhere if position has sufficient challenge. MW 76, The Modern Hospital, 919 N. Michigan, Chicago 11.

**ADMINISTRATOR**—Male, age 37; desires appointment fifty to one hundred bed hospital; formal training and experienced in all phases of hospital administration; well recommended; available within sixty days; prefer middle west. MW 61, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**ANESTHETIST**—With fifteen years' experience all types anesthesia; given over several thousand cases curare, sodium pentothal. MW 27, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**DIRECTOR OF NURSING**—General hospital, no school; vicinity of New York City preferred; will also consider Philadelphia area. MW 67, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**PURCHASING AGENT**—Man with extremely valuable experience in all phases of purchasing wants to come into hospital field; has supervised personnel in his well rounded business career; age 50; B.S. Degree; married; energetic, conscientious, honest and resourceful. MW 74, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

### INTERSTATE HOSPITAL AND PERSONNEL BUREAU

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Cleveland, Ohio

**ADMINISTRATOR**—B.S. Degree, Business Administration; M.S. Degree, Hospital Administration; completed one year's internship, large mid-western hospital; past year administrative assistant.

**BUSINESS MANAGER**—Or assistant director; 12 years public auditor; 5 years office manager-accountant, 300-bed eastern hospital.

**SUPERINTENDENT**—Age 38 years; A.B. Degree, western university; 6 years superintendent, 75-100-bed hospitals, southwest; desires change.

**SUPERINTENDENT**—FACHA; outstanding nurse-administrator; 12 years experience, 125-bed hospital; graduate nurse staff; highly recommended.

**EXECUTIVE HOUSEKEEPER**—10 years resident manager, Chicago hotel; 5 years large mid-western hospital; prefers southwest.

### THE MEDICAL BUREAU Burnice Larson, Director Palmolive Building Chicago 11, Illinois

**ADMINISTRATOR**—Master's in Hospital Administration; year's administrative residency, 500-bed voluntary hospital; three years, assistant administrator, 400-bed hospital.

**ADMINISTRATOR**—Medical; four years, assistant administrator, teaching hospital; eight years, administrator, fairly large hospital; FACHA; highly regarded nationally.

**ADMINISTRATOR**—Young lawyer formally trained in hospital administration; L.L.B., eastern university; several years, practice of law during which time he taught Business Law; year's administrative residency, teaching hospital.

**ADMINISTRATOR**—Graduate nurse, thoroughly experienced in all phases of hospital work with bed capacities from 75-300; twelve years, administrator, 175-bed hospital.

**ASSISTANT ADMINISTRATOR**—Graduate nurse; professionally trained, university hospital; Master's in Hospital Administration; recently completed administrative residency, eastern hospital.

**ANESTHESIOLOGIST**—Diplomate, American Board; several years' private practice, anesthesiology; prefers directorship, hospital department.

**EXECUTIVE HOUSEKEEPER**—Several years hotel housekeeping director; three years, executive housekeeper, 200-bed hospital.

**LAUNDRY MANAGER**—Twelve years' laundry manager, 400-bed hospital; past three years, laundry superintendent, 800-bed teaching hospital.

**PATHOLOGIST**—Diplomate of American Board; eight years, pathologist and director of laboratories, teaching hospital, during which time he has served as associate professor of pathology in university medical school.

**PHYSIATRIST**—Physician, specialist in physical medicine; five years, director of physical medicine, 600-bed hospital.

**SOCIAL WORKER**—M.S., Social Administration, past several years, medical social worker, teaching hospital.

**RADIOLOGIST**—Diplomate, American Board, Therapeutic and Diagnostic; several years, director, radiology 300-bed hospital; currently engaged in radiology, group clinic; prefers directorship of hospital x-ray department; Fellow, American College of Radiology.

**TUBERCULOSIS**—Specialist trained in thoracic surgery, experienced in administration; past several years in charge of small sanatorium.

### MEDICAL PLACEMENT AND MAILING SERVICE

Mrs. Stewart Roberts  
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Atlanta, Ga.

**PSYCHOLOGIST**—Master's Degree 1947; wants position with hospital or psychiatrist.

(Continued on page 174)

### MEDICAL PLACEMENT AND MAILING SERVICE—Continued

**HOSPITAL ADMINISTRATOR**—Master's Degree Hospital Administration, Columbia University; years of experience, good references; capable administering large hospital; has supervised building construction.

**PATHOLOGIST**—Wants connection with southern hospital.

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**ADMINISTRATOR or SUPERINTENDENT**—Age 41; Master's Degree in Hospital Administration; well rounded experience in all phases of hospital administration; last 4 years superintendent 100-bed hospital.

**ADMINISTRATOR**—Age 32; Master's Degree, Hospital Administration; excellent training and practical experience.

**RADIOLOGIST**—Age 46; Certified both Boards; 17 years private practice; during this time was chief radiologist in several large hospitals, instructor class A medical school and consultant; immediately available.

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**RADIOLOGIST**—35; certified; therapeutic or diagnostic; Vanderbilt University graduate; hospital, clinic and army experience; all localities considered; immediately available.

**ADMINISTRATOR**—Lay; outstanding organization ability; experience includes ten years executive director large eastern clinic; five years important western hospital; outstanding business experience in commercial world including ownership smaller bank; well known to us; highly recommended.

**ADMINISTRATOR**—Lay; age 38; outstanding record of hospital administration large university hospital; also hospital administration lecturer; interested only hospitals 250 beds or larger; NACHA.

**ADMINISTRATOR**—Lay; age 30; M.A. Hospital Administration; two years administrative residency; two years assistant administrator 225-bed hospital; prefers northwest 75-150 bed hospital; consider other localities; available 30 days.

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## Want Advertisements

### POSITIONS WANTED

#### WOODWARD—Continued

**PATHOLOGIST**—Certified; age 35; three years residency university hospital; four years assistant professor university hospital; will teach either; seeks hospital association in community not less than 50,000; financial return not as important as pleasant working conditions; immediately available.

**ADMINISTRATOR**—Graduate nurse; can assume full responsibility teaching program; fifteen years excellent experience; broad knowledge every phase; interested 150-bed hospital; personally known; recommended.

### POSITIONS OPEN

**ANESTHETIST**—Assistant; for new 80-bed general hospital; experience necessary. Apply, Administrator, Lexington Memorial Hospital, Lexington, North Carolina.

**ANESTHETIST**—Nurse; small, modern hospital in Pennsylvania; conveniently located; excellent salary and living quarters; state full details and date available. MO 66, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**ANESTHETIST**—Nurse; for 300-bed hospital; four anesthetists now on service; salary open. Apply, D. W. Hartman, Superintendent, The Williamsport Hospital, Williamsport, Pennsylvania.

**ANESTHETIST**—Nurse anesthetist; wanted for 75-bed general hospital; congenial working conditions; ideal for individual wishing to become established in small city. Write full particulars to MO 47, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**ANESTHETIST**—Preferably a nurse; 75-bed approved hospital; salary \$300 a month and maintenance; P.M. Saturday and all day Sunday off; on call during week. St. Mary's Hospital, Emporia, Kansas.

**DIETITIAN**—Assistant; ADA member, teaching and therapeutics, 125-bed general hospital, Frederick Memorial Hospital, Frederick, Maryland.

**DIETITIAN**—Assistant; wanted for 200-bed tuberculosis hospital; good salary plus room, board and laundry; please send small photograph or snapshot with letter of application stating qualifications and pertinent personal details. Apply Superintendent, Indiana State Sanatorium, Rockville, Indiana.

**DIETITIAN**—Registered; wanted for a fully approved 150-bed hospital; good salary and pleasant surroundings. Apply Mother Marie, Maryview Hospital, Portsmouth, Virginia.

**DIETITIAN**—For 112 tuberculosis hospital; average 90 patients; salary open. Apply, M. W. Newcomb, M.D., Superintendent and Medical Director, M. W. Newcomb Hospital for Chest Diseases, New Lisbon, New Jersey.

**DIETITIAN**—Staff; fully approved 373-bed general hospital; 44-hour week, vacation and sick leave policy. Write, Personnel Director, Aultman Hospital, 625 Clarendon Avenue, Southwest, Canton 10, Ohio.

**DIETITIAN**—90 beds, 24 bassinets, in Vermont; completely new kitchen and cafeteria service; duties include administration of department; diet therapy instruction, etc.; salary open; ski season starts soon. MO 65, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

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**INSTRUCTRESSES**—Science and two clinical instructresses; 130 students. Apply for further information to Director of Nursing, St. Joseph's Hospital, Victoria, British Columbia.

**INSTRUCTOR OF NURSES**—For 140-bed accredited general hospital with training school of 50 students; salary open; 5½ day week; 1 month vacation with pay and statutory holidays; town of 10,000. Apply Superintendent, Aberdeen Hospital, New Glasgow, Nova Scotia.

**INSTRUCTOR**—Qualified; at once; 100-bed hospital, 45 students; hospital is 40 miles from Edmonton with good train and bus service; salary schedule according to experience; 8-hour day, 5½ day week with long week-end once a month; 1 month holiday with pay at end of 1 year. Apply by wire collect or write, stating salary expected, Superintendent of Nurses, Public Hospital, Lamont, Alberta.

(Continued on page 176)

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COMBINATION ARM, LEG & HIP UNIT  
Mobile Model HMA 200  
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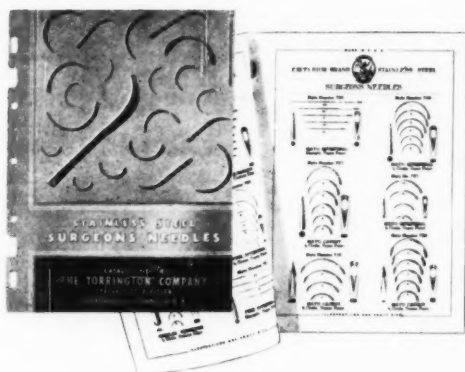
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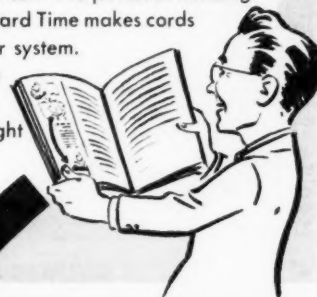
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Replace your worn out nurses calling cords with STANDARD LIFE-LONG Cords. They'll give service that lives up to their name.

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**INSTRUCTORS**—Nursing arts; also 2 Clinical instructors in surgery; for a collegiate nursing program; salary open. Apply, Chairman, Division of Nursing, Dillard University, New Orleans 19, Louisiana.

**LIBRARIAN**—Chief medical record; for university hospital; must be registered and experienced in both clinic and private record room operations; must have supervisory ability; general hospital of 400 beds and out-patient department with yearly census of 116,000 visits. Apply, Personnel Department, Stanford University Hospitals, Clay and Webster Streets, San Francisco 15, California.

**LIBRARIAN**—Medical records; registered record librarian for position at Hospital for Sick Children, Toronto; give experience and references. Apply to Superintendent, 67 College Street, Toronto, Ontario.

**LIBRARIAN**—Medical record; assistant; fully approved 375-bed general hospital; 44-hour week; vacation and sick leave policy. Write, Personnel Director, Aultman Hospital, 625 Clarendon Avenue, Southwest, Canton 10, Ohio.

**MISCELLANEOUS**—Assistant administrator of nursing service and administrative supervisors in operating room, pediatrics and obstetrics; for fully approved 275-bed general hospital with basic and collegiate nursing programs; degree and experience preferred; salary open. Write, Director of Nursing, Central Maine General Hospital, Lewiston, Maine.

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**NURSES**—Graduate staff, for small, new, fully modern general hospital in southern Indiana, close to several large cities in Indiana, Kentucky and Illinois; beginning salary \$180 with additional for evening and night duty; Surgical nurse, salary \$190. MO 67, The Modern Hospital, 919 N. Michigan Avenue, Chicago, 11.

**NURSES**—Registered; for 200-bed tuberculosis hospital; good salary, plus room, board and laundry. Apply, Superintendent, Indiana State Sanatorium, Rockville, Indiana.

**NURSES**—Registered nurses and registered psychiatric nurses; men and women; for state hospital assignments, for general duty, hospital work, tuberculosis and psychiatry; also registered psychiatric nurses with college degree as instructors of affiliating schools of psychiatric nursing; good salaries; opportunity for advancement; excellent retirement and insurance plan. Write, Division of Personnel Service, Department of Public Welfare, State Armory, Springfield, Illinois.

**NURSES**—Staff; urgently needed for communicable diseases and tuberculosis nursing in large, modern hospital; salary, \$1968 per year with increments to \$2268; additional allowances of \$200 per year for tuberculosis nursing; full maintenance; 44 hours duty per week; 6 legal holidays; paid vacation of 3 weeks per year; accumulative sick leave allowance; generous retirement plan. Apply to Superintendent of Nurses, Philadelphia Hospital for Contagious Diseases, 4000 N. Front Street, Philadelphia 40, Pennsylvania.

(Continued on page 178)



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Is this newborn infant's name Ross or Moss? Kane or Payne? Does he belong to the Archibald Smiths or the Spencer Smiths? There is no doubt when Deknatel Name-on Beads are sealed on baby at birth. Deknatel, "the original" Name-on Beads are color fast, indestructible, inexpensive. Not affected by washing or sterilizing. The necklace stays on until it's cut off.

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Evenflo is now  
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Evenflo—Approved by Doctors and Nurses

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**PSYCHIATRISTS**—Openings for senior, assistant and junior; for staff or progressive and fully approved state hospital; excellent salary and full maintenance. Write, Superintendent, Delaware State Hospital, Farnhurst, Delaware.

**RESIDENCY**—Approved; in radiology; available at Newark City Hospital. Inquiries to Dr. R. Pomeranz, 31 Lincoln Park, Newark 2, New Jersey.

**RESIDENCY**—Anesthesiology; at the Veterans Administration Hospital, Aspinwall, Pennsylvania; affiliated with the University of Pittsburgh; 925 beds; large clinical service and excellent basic science course; opening available at once and January, 1959. For further information write, Secretary, Dean's Committee, University of Pittsburgh School of Medicine, Pittsburgh 13, Pennsylvania.

**SUPERINTENDENT OF NURSES** For the Madison County Tuberculosis Sanatorium, Edwardsville, Illinois; salary \$275 per month and complete maintenance; pension plan in operation. Address, Loren L. Collins, M.D., Superintendent.

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(Continued on page 180)

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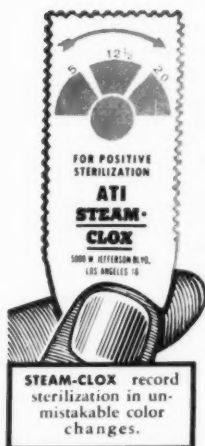
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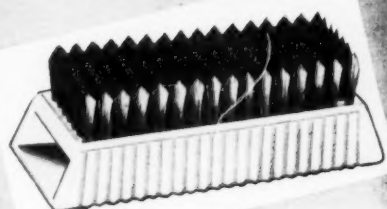
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DIRECTOR OF NURSES — Oregon hospital with school of nursing; no degree required; plans for early expansion to 150 beds; full time assistant and full time secretary in nursing office; extremely pleasant location.

#### BUSINESS AND MEDICAL REGISTRY —Continued

ASSISTANT DIRECTOR OF NURSES — To relieve dean of college of nursing and assist with nursing service; degree and some administrative or teaching experience; excellent connection for ambitious young woman; southern California.

DIETITIANS — (a) 200-bed central California county hospital; \$275; forty hour week. (b) Veterans hospital; 500 beds; administrative dietitian; forty hour week; \$250; excellent low cost maintenance. (c) Home economist; Master's Degree; for teaching and supervision of home making department; southern California college; \$300 and maintenance.

OBSTETRICAL SUPERVISORS — (a) A twenty bed unit in large bay area hospital; forty hour week, paid vacation, sick leave, social security; \$279; degree preferred but good experience given consideration. (b) Seventeen bed unit of 65-bed southern California hospital; 40-hour week, post course or good experience; \$235 with maintenance. (c) Well known hospital in famous resort city; post course required.

ASSISTANT INSTRUCTOR OF NURSING ARTS — Degree required plus experience or teaching preparation; teaching responsibility primarily in nursing arts but some specialty teaching included; 40-hour week, paid vacation, sick leave, social security; \$276.

(Continued on page 182)

#### INTERSTATE HOSPITAL AND PERSONNEL BUREAU

Miss Elsie Dey, Director  
332 Bulkley Building  
Cleveland, Ohio

ADMINISTRATOR — (a) 120-bed hospital; Pennsylvania. (b) 65-bed Ohio hospital; new addition. (c) 85-bed hospital; western Virginia. (d) 75-bed hospital; North Dakota. (e) 35-bed hospital; Colorado.

ASSISTANT ADMINISTRATOR — (a) Experienced accountant; Degree Hospital Administration; ideal situation; New England. (b) 150-bed Ohio hospital; residence furnished; registered nurse considered.

DIRECTOR OF NURSES — (a) Graduate staff; 150-bed hospital; southern Wisconsin. (b) 300-bed tuberculosis sanatorium; mid-west. (c) 100-bed Michigan hospital; resort area. \$325. (d) 90-bed new Ohio hospital; college town; \$400.

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EDUCATIONAL DIRECTOR — (a) 225-bed hospital; new teaching unit; large industrial city; mid-west. (b) 300-bed hospital; east; \$275; maintenance.

PHYSICAL THERAPIST — (a) 350-bed Ohio hospital; \$300; new department. (b) 200-bed hospital; South Carolina; \$290; maintenance.

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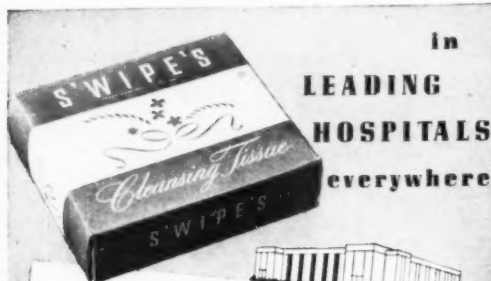
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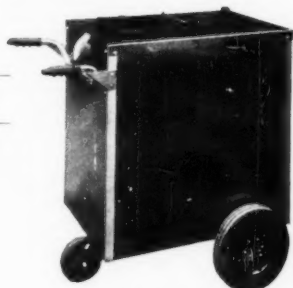
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Three Inches  
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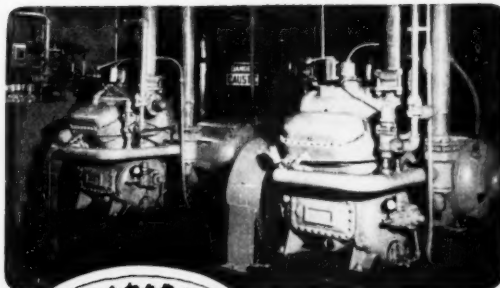


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For Storage and Mobility  
All Stainless Steel

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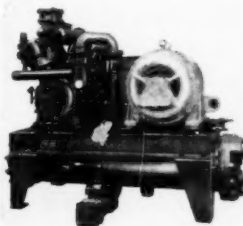
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Have 2, 3, 4, or 6 Cylinders,  
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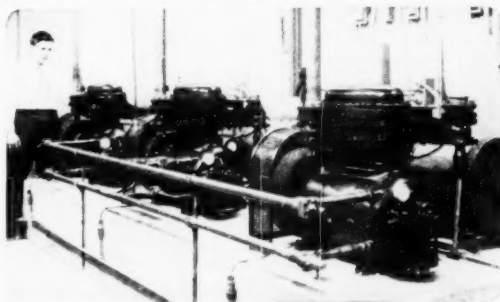
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## Want Advertisements

### POSITIONS OPEN

#### INTERSTATE—Continued

**RECORD LIBRARIAN**—(a) 200-bed eastern hospital; \$225, maintenance. (b) 310-bed hospital; New York; 3 assistants; 44-hour week. (c) 120-bed hospital; Wisconsin. (d) Assistant; 200-bed Ohio hospital; \$200.

**ADMINISTRATIVE DIETITIAN**—(a) 175-bed hospital; mid-western university city. (b) Therapeutic; attractive locations; \$250-\$275.

**X-RAY TECHNICIAN**—(a) 50-bed Michigan hospital; new department; one assistant; \$200, maintenance. (b) 200-bed hospital; east.

**LABORATORY TECHNICIANS**—(a) To \$250, maintenance. (b) Laboratory x-ray; \$200-\$300.

**HOUSEKEEPERS**—(a) 250-bed hospital; near New York. (b) Housekeeper; large nurses' residence; Ohio. (c) 200-bed hospital; Kentucky.

#### THE MEDICAL BUREAU Burneice Larson, Director Palmolive Building Chicago 11, Illinois

**ADMINISTRATORS**—(a) Medical director; one of country's leading hospitals affiliated with university school of medicine; nearly thousand beds; much sought-after location. (b)

#### MEDICAL BUREAU—Continued

Lay or medical; large general hospital; municipally operated; \$8000-\$10,000; Pacific Coast. (c) Lay; general; 175 beds; Master's degree and experience as assistant administrator, large hospital or as administrator of small hospital required; town of 60,000, middle west. (d) Lay; municipally operated hospital, fairly large size; coastal city, south. (e) Assistant director; tuberculosis hospital; although tropical country, climate mild. (f) Medical and assistant medical administrators; one of largest hospital groups in country; teaching affiliations; homes or apartments provided. (g) Assistant medical director; 400-bed hospital; east. (h) Lay; 400-bed teaching hospital, modern in every way; university medical center, middle west. (i) Lay; general hospital; 70 beds; college town, east. (j) Lay; new hospital of small size to be completed January; college town, middle west. (k) Assistant administrator; 150-bed hospital; preferably one with accounting background; midwest. (l) Assistant administrator; general 300-bed hospital; knowledge of building construction and engineering desirable; metropolitan area of east. (m) Lay or medical; 250-bed hospital; college town, 40,000, west. MH12-1.

**NURSE ADMINISTRATORS**—(a) New hospital of small size now being completed; residential town, short distance from university center. (b) School for mentally retarded children; suburb, middle western metropolis. (c) General hospital, 200 beds, should be willing to serve as assistant until retirement of present administrator within six months. (d) Convalescent home for children located on outskirts of university medical center; south. MH12-2.

#### MEDICAL BUREAU—Continued

**ANESTHETISTS**—(a) Clinic of twelve specialists; modern, well equipped hospital; interesting town in mountainous area of southwest; \$3600-\$4300. (b) One of California's leading hospitals; medical anesthetologist in charge. (c) Two; general hospital, 400 beds; active surgery; minimum, \$300, complete maintenance; middle west. (d) Two; university hospital, 350 beds; \$350 increasing to \$375 within six months; east. (e) One of most modern hospitals in Hawaii; delightful location. MH12-3.

**DIETITIANS**—(a) Chief administrative dietitian; staff of seven assistants; 400-bed general hospital; east. (b) General hospital operated under American auspices in South America; staff of well qualified physicians. (c) Home economics department, large food manufacturing company; should be experienced in quantity food cooking, qualified to develop recipes for hotels, institutions; should have fairly wide interest in writing; duties involve some traveling; \$6000. (d) Food service manager; new hospital; approximately 1000 meals daily. (e) Nutritionist; university appointment; duties consist of consultant service for pediatric and obstetrical patients and conducting clinics. MH12-4.

**EXECUTIVE HOUSEKEEPERS**—(a) Fairly large hospital in metropolitan New York. (b) Large general hospital; university center; south, \$3600-\$4000, MH12-6.

**EXECUTIVE SECRETARY**—State nurses' association; public health nursing experience desirable; considerable traveling. MH12-7.

(Continued on page 184)

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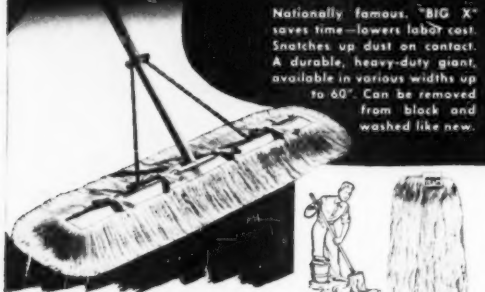
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To acquaint you with some aspects of the law, and to suggest measures which you can take to protect both yourself and your institution, Insurance Company of North America has prepared a pamphlet which will assist you to review your responsibilities.

Court decisions are cited defining trustee responsibility for the preservation of properties, funds and other assets, and the safeguarding of life. The important role that insurance plays in protecting you in the proper discharge of your responsibilities, both legal and moral, is explained. Also outlined are the services of Insurance Agents or Brokers in obtaining a comprehensive survey so that adequate protection may be obtained.

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Thousands upon thousands of SECO-WARE can combinations are now operating profitably by an ever-increasing number of users. The SECO-SYSTEM of hot and cold food storage has rapidly moved to a first place from an accepted second to a most favored purveyors are specifying the SECO-SYSTEM as the answer to their individual food serving problems.

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## Want Advertisements

### POSITIONS OPEN

#### MEDICAL BUREAU—Continued

**DIRECTORS OF NURSES**—(a) Voluntary hospital, general, 800 beds; 300 students; faculty of 14; university medical center; \$6000, maintenance. (b) Fairly large hospital; relatively new; fashionable winter resort town, Florida. (c) General hospital, 300 beds; expansion program; school of 60 students. (d) One of the country's largest teaching hospitals; duties principally administration, public relations; associate directors in charge of school, nursing service; preference for someone with doctorate; \$7200, maintenance. (e) One of country's leading hospitals for children. (f) Director of nursing service; small general hospital; all-graduate staff; \$4500, maintenance, including private apartment; college town, southeast. (g) Assistant director of nursing service; teaching hospital; delightful location; completely furnished private suite provided in beautiful new apartment building; middle west. MH12-5.

**FACULTY APPOINTMENTS**—(a) Clinical instructors in obstetrics and psychiatry; large teaching hospital; \$4500; east. (b) Educational director; 200-bed hospital affiliated with state university; teaching duties light; west. (c) Nursing arts and clinical instructors in medicine and surgery; 300-bed hospital; teaching affiliations; 200 students; midwest. MH12-8.

#### MEDICAL BUREAU—Continued

**MEDICAL RECORD LIBRARIANS**—(a) To succeed retiring director of department; staff of eight; 800-bed hospital; east. (b) Chief; large teaching hospital; east. (c) Chief; to reorganize department, well-known university hospital; south. (d) To organize and direct departments, three small hospitals within twenty-three mile radius; college town, Pacific northwest. MH12-9.

**PHARMACISTS**—(a) Chief, to take complete charge of pharmacy for 300-bed general hospital with associated professional building now under construction containing offices for 30 physicians. (b) Associate; 700-bed teaching hospital; preferably one qualified to succeed chief upon his retirement. MH12-10.

**PURCHASING AGENT**—Large voluntary hospital, fully approved; purchases amount to half million annually; east. MH12-11.

**SUPERVISORS**—(a) Central supply; new department, splendidly equipped; 250-bed hospital; preferably one qualified to establish policies; New England. (b) Obstetrical and, also, floor; hospital of medium size; fashionable winter resort town, Florida. (c) Operating room; general hospital, 200 beds; one of wealthiest cities in United States; university center; \$300, maintenance. (d) Pediatric; new hospital; college town, \$4000. (e) Surgical pavilions and operating room department; general hospital operated under American auspices in Asia; transportation provided. MH12-13.

#### MEDICAL PERSONNEL EXCHANGE

**Nellie A. Gealt, R.N., Director**  
4707 Springfield Avenue  
Philadelphia 43, Pennsylvania

**ANESTHETISTS**—(a) Hawaii; February 1st; \$300; transportation refunded after a certain length of service. (b) Ohio; \$350; maintenance.

**DIRECTOR OF NURSES**—75-bed; graduate staff; \$300; partial maintenance.

**DIETITIAN**—Chief; 125-bed; Virginia.

**EDUCATIONAL DIRECTOR**—Large hospital; eastern Pennsylvania; \$3600; maintenance.

**EXECUTIVE HOUSEKEEPER**—300-bed leading hospital, with an extensive building program under way; attractive living quarters.

**RECORD LIBRARIAN**—New York; starting \$2400; maintenance.

**PHYSIOTHERAPIST**—Head; new department; 260-bed hospital; starting \$300.

**OCCUPATIONAL THERAPIST**—Children's hospital; starting \$200; meals and laundry.

**PHARMACIST**—125-bed Pennsylvania; salary open; maintenance.

**TECHNICIANS**—(a) X-Ray; 50-bed hospital; \$260. (b) Laboratory; \$225.

**RESIDENT PHYSICIAN**—For a small general hospital; must be graduate of a class A medical school; salary \$500 per month and maintenance.

We make no charge for registration.

(Continued on page 186)

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## Want Advertisements

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DIRECTOR OF NURSES—South; university town of 50,000; 175-bed hospital affiliated with university; school of nursing has student body of 40; contract being let for completely new hospital with 200 beds, and nurses home of 100 beds; present nurses home consists of 2, two-story brick buildings with excellent classroom facilities and comfortable living quarters; there are at present 45 graduate nurses including supervisors and instructors; university recently established a collegiate school of nursing; salary open.

(Continued on page 188)

#### SHAY—Continued

MEDICAL-SURGICAL CLINICAL INSTRUCTOR—Southeast; in winter resort area; B.S. Degree required; student enrollment 56; with an entering group of approximately 20, they have two 3 month affiliations so that number of students available in school program during year is thereby reduced; 150-bed hospital with new building program in process which will be completed in November of this year; faculty group consists of an educational director and nursing arts instructor; salary \$3600 plus maintenance.

NURSE ANESTHETIST—Southwest; private clinic; all members well qualified, Boardmen or eligible; college town of 15,000 situated in beautifully scenic country; \$4800 start.

DIETITIANS—(a) Therapeutic, assistant to chief dietitian; east; 283-bed hospital, approved for teaching student nurses, interns, residents; \$250, maintenance. (b) Teaching; middle west; 340-bed general hospital, city of 190,000. (c) Executive; east; 190-bed hospital, near New York City; experienced; ADA not necessary; \$300 plus maintenance; increments given every six months. (d) Chief; south; 100-bed hospital located in city of 80,000; many cultural advantages; duties include, general supervision of dietary department, purchasing, instruction in nutrition and diet therapy; \$300 plus maintenance.

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Feet won't slip  
on Hilco-Lustre  
floors. That's  
why slip-  
resistant  
Hilco-Lustre  
is approved  
by Underwriters'  
Laboratories  
for underfoot safety.

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Slip-Resistant  
Hilco-Lustre*

**FAST, EFFICIENT** Liquid Hilco-Lustre spreads quickly. Requires no buffing or polishing. Dries in 30 minutes. Effective on every type of floor.

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**SPEEDS MAINTENANCE** Hilco-Lustre saves you time and effort. Tough surface coat keeps dirt from digging in. Floors stay lustrous longer...need only occasional cleaning with HILLYARD'S Super Shine-All.

**SAFE** Hilco-Lustre is double-safe for your floors...safe to walk on, safe to use on any kind of floor surface.



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**ADMINISTRATORS**—(a) Medical clinical director; 1000-bed state mental institution; \$11,000 pending legislative approval; \$8,400 currently; housing maintenance. (b) Lay; 100-bed approved teaching hospital; southeastern college city; 80,000. (c) Lay; 140-bed approved teaching hospital; attractive smaller community; Pennsylvania. (d) Lay; 60-bed ACS approved hospital; new wing under construction; eastern seaboard city; \$5000. (e) Lay; male or female; 50-bed Florida hospital; good business experience, knowledge of hospital administration essential; above average salary. (f) Lay; 40-bed hospital now under construction; will be beautifully equipped; smaller county seat community; southern scenic mountainous region. (g) Lay; 30-bed Wisconsin hospital under construction; community 6000 in attractive agricultural area near university center. (h) Lay; female; 27-bed Indiana hospital; well equipped and staffed. (i) Lay; male or female; nice hospital of 26 beds; adding 25-bed wing; New York summer resort city; death occasions vacancy. (j) Lay; excellent 140-bed hospital; near international boundary line in Michigan; \$4800 plus fine 8 room rent free home.

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(Continued on page 190)

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# Steam is the most economical cooking medium.

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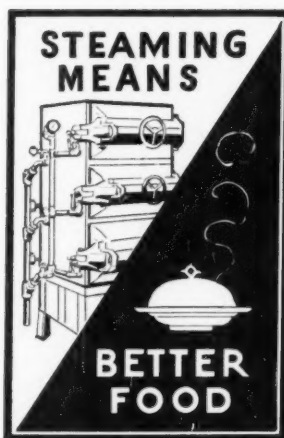
(Leading hotels, restaurants, hospitals, schools, institutions)

# Steam-Chef is the most efficient steam cooker.

(Built by specialists who make nothing else)



For vegetables, meats, fish, desserts and many other items, Steam-Chef has no superior in time and labor



saving, reduction of shrinkage and waste, and *finer* food preparation. Made in several sizes and types to suit *your* requirements, operated by steam, gas or electricity. Send for Catalog, also helpful booklet "For Better Steaming."

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For BETTER Steaming-  
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# SOLVED

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• It's always a problem to satisfy the natural dessert craving of patients on diabetic and reducing diets. D-ZERTA, a truly delicious gelatin dessert, is a welcome answer for patients on these low-carbohydrate and low-calorie diets.

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#### FOR LEASE

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(Continued on page 192)

## NEW! Dresser-Desk-Vanity All in One!



**EICHENLAUBS  
VANDRESK  
NO. 1056**

The Vandresk is completely enclosed—can be used in the center of the room as well as against a wall. It serves as dresser, desk, and vanity—simplifies furnishing the room—and saves 1/3 the cost!

It is made of cherry—America's most beautiful native hard wood. There are three drawers in the dresser section;

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WRITE FOR A FREE DEMONSTRATION on your own floors  
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Not Drops . . . Not a Jet . . . A SPRAY

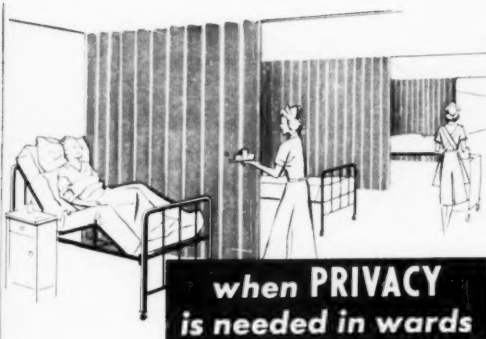
● Now in an especially designed dispenser bottle that is easy to operate, this new glass container ejects Ethyl Chloride in a fine MIST-LIKE CONCENTRATED SPRAY.

The spray is entirely automatic, no adjustment being necessary. Compared with a jet stream (for local anesthesia) much less liquid is used, thus greater economy.

*Dose: Chemical Ethyl Chloride U.S.P. is used in this package.*

*Write for latest catalog of hospital specialties*

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New Castle Indiana  
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**Waterproof**  
**MATTRESS**  
**COVER**  
with Zipper

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Vinyl-Film .004 gauge with full width Zipper Closure. SIZE: 77"x36"x6".  
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Easily washed. Protection to allergy sufferers. Size 22" x 28". With zipper. No. MA246  
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Muslin covered. Can be bent, rolled or folded. Vermin, damp and mold proof.  
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### SCHOOLS—SPECIAL INSTRUCTION

QUEEN OF ANGELS HOSPITAL, Los Angeles, California, offers a six-month course for graduate nurses in obstetrics. Classes admitted January 15 and July 15. For further information apply to the Director of Nursing, 2301 Bellevue, Los Angeles 26, California.

ST. FRANCIS HOSPITAL, Peoria, Illinois, offers a comprehensive course in Anesthesia to graduate nurses of accredited schools of nursing, and is open to Sisters. This course includes all types and methods of Anesthesia in use today. For further information write to Sister M. Borromea, R.N., Director, School of Anesthesiology, St. Francis Hospital, Peoria, Illinois.

### SCHOOLS—SPECIAL INSTRUCTION

The PROVIDENCE LYING-IN HOSPITAL, offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and a stipend of \$60 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

HERRICK MEMORIAL HOSPITAL offers the following programs in the Herrick School of Hospital Arts: 12-month course for Medical Record Librarians; 24-month course for x-ray technicians; 12-month course for practical nurses. Courses G.I. approved or approval pending. For further information, apply to the Director, Herrick School of Hospital Arts, 2001 Dwight Way, Berkeley, California.

#### SCHOOL FOR LABORATORY TECHNICIANS

Duration of course, 1 year. Tuition, \$100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Mo.

### SCHOOLS—SPECIAL INSTRUCTION

The MARGARET HAGUE MATERNITY HOSPITAL. The largest hospital in the country offers the following to registered, professional nurses of accredited schools:

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Included are obstetric lectures, nursing classes, techniques, laboratory science, nutrition, mothers' health and socio-economic aspects. Supervised experience is given in antepartal, intrapartal, postpartal and newborn infant care with a minimum of twenty-five hours of clinical instruction. Students may elect one month's experience in premature nursery, formula room, isolation, antepartal or clinic and field service.

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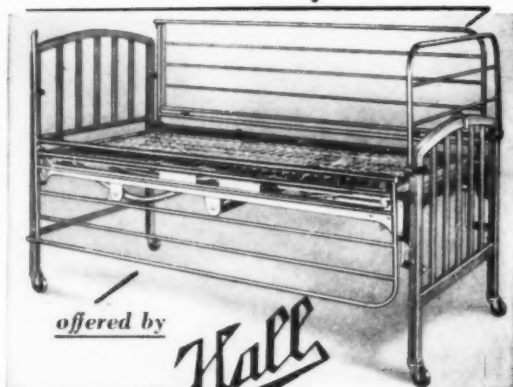
Following the above program, a two months' course is offered to students who have demonstrated potentialities for head nurse responsibilities. It includes instruction in principles and methods used in clinical teaching program and ward management. Students plan and conduct their program of clinical instruction with the head nurse and serve as assistants. They are directed and supervised by the instructor of the course.

Classes admitted every other month beginning February. Maintenance and stipend of \$75.00 per month granted. Write for catalogue, Address Rose A. Coyle, R.N., Director of Nurses, 88 Clifton Place, Jersey City 4, New Jersey.

SIMMONS COLLEGE SCHOOL OF NURSING offers two one-year programs in public health nursing and in clinical teaching and administration. The N.O.P.H.N. accredits the public health nursing program. Both programs include class instruction and supervised experience. Simmons College offers to graduates of accredited schools of nursing a program of approximately three years including liberal arts and nursing courses leading to the degree of Bachelor of Science. Admission September and February. Address inquiries to Director, School of Nursing, Simmons College, Boston.

SKIDMORE COLLEGE in association with the New York University-Bellevue Medical Center of New York University, University Hospital, offers to graduates of accredited schools of nursing, supplementary programs in management and teaching and in operating room technique. Admission dates for seven months' operating room program are the fifteenth day of March and September. Students are admitted for one year program in unit management and teaching the first Monday in October. For details write Director, School of Nursing, 303 East 20th Street, New York 3, New York.

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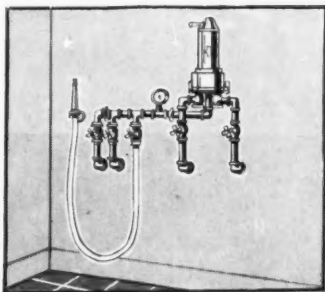
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## FOR HYDROTHERAPY CONTROL



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...about our No. 339  
 Surgeon's Gown. It's  
 practical and longer  
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## The Wringer that CUTS FLOOR CLEANING TIME

**25% to 50%**

*Geerpres Mop Wringers  
 do this because:*

**SINGLE TANK AND TWIN TANK  
 FOR MOPS UP TO 16 OZ.  
 FOR MOPS UP TO 24 OZ.  
 FOR MOPS UP TO 36 OZ.  
 ALSO "TANGLEPROOF" MOPSTICKS**



1. One operation of the handle extracts twice as much water as 2 operations with other wringers.
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Shown: No. 2436 Outfit Complete

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Waterproof, resistant to stains and acids  
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Is non-toxic, soft  
and non-abrasive

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Is firmly anchored  
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# *like a* **Sword of** **Damocles**



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this threat . . . use Ray-Tec X-ray Detecta-  
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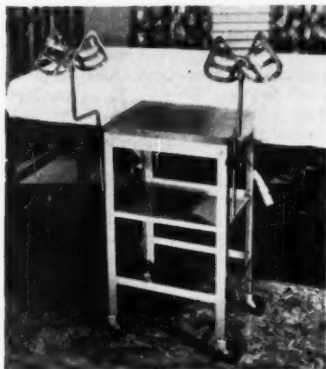
*Johnson & Johnson*

# What's New for Hospitals

DECEMBER 1949

Edited by BESSIE COVERT

## Gynecologic Examining Cart



The new Gynocart is a mobile bedside gynecologic examining cart, devised by Dr. M. H. Meyerhardt of St. Louis, and developed by A. S. Aloe Company. It is designed to save time of moving the patient to an examining room for a routine gynecologic examination or treatment. The Gynocart has a shelf for carrying a sterile tray, Baumanometer and other supplies or equipment needed. The stethoscope or other apparatus can be hung from hooks provided for the purpose. The cart is equipped with adjustable Bierhoff crutches. When needed, it is wheeled to the patient's bedside and attached to the frame or spring by means of adjustable leather straps.

The cart is made of stainless steel and can be used, without the crutches, for routine dressings, as an arm board for blood pressures and other requirements. A. S. Aloe Co., Dept. MH, 1831 Olive St., St. Louis 3, Mo. (Key No. 63)

## Cholelithophone

The Kirby-Thurston Cholelithophone is an electro-acoustic device designed to detect and locate gallstones during a surgical operation. A sensitive probe inserted into the duct relays a characteristic signal to a loudspeaker upon contacting a stone. The device has been suggested for the detection of other calculi and other uses are now under investigation.

Maintenance of the Cholelithophone is simple, requiring no special skill, and probe parts are sterilizable. Replacement of tubes and plug-in condenser once a

year at time of checking is the only upkeep necessary. It is carefully designed and constructed for trouble-free operation. The device operates from any 115 volt AC outlet. Geo. P. Pilling & Son Co., Dept. MH, 3451 Walnut St., Philadelphia 4, Pa. (Key No. 64)

## Anacap Silk Suture on Spools

Anacap surgical silk is now available on spools, unsterilized, for those who prepare and sterilize their own silk sutures. It is available on spools holding 25 and 100 yards in sizes 6-0 to 5. Anacap silk is readily sterilized by boiling or autoclaving. The spools are packaged in a transparent, plastic container which protects the silk from dust and dirt. Davis & Geck, Inc., Dept. MH, 57 Wiloughby, Brooklyn 1, N.Y. (Key No. 65)

## Low Floor Machine



Especially designed for institutional use, the new Silent Huntington Low-Hite Floor Machine is only 11 inches high, from floor to top of motor housing. It is low enough to scrub and polish under most furniture, yet heavy enough for quality work. The Silent Huntington Built Drive is installed on the new machine for use in hospitals.

The new machine is designed to polish, scrub, buff, wax, steel wool and shampoo. It is quiet and efficient and is equipped with a safety grip switch. It is available in 12 or 16 inch sizes with a quiet planetary gear drive. An additional feature of the new machine is the retractability of the wheels which can be pulled out of the way when the machine is in operation. Huntington Laboratories, Inc., Dept. MH, Huntington, Ind. (Key No. 66)

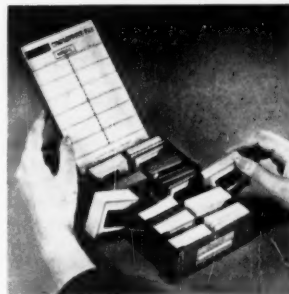
## Wet or Dry Vacuum Cleaner

A new wet or dry vacuum cleaning system has been developed for institutional use which is powerful, efficient and easily mobile. It operates without belts, dust bags or brushes and with available attachments the machine will handle a wide range of cleaning problems. It is equipped either as a dry pick-up machine or, with an adapter, as wet and dry pick-up machine.

The sturdy, compact design and low center of gravity make the machine easy to maneuver in confined areas. Four hard rubber swivel casters also add to its maneuverability. All seams below the water line are double electro-welded and the tank is lined with a corrosion resisting finish. Standard equipment includes flexible hose, steel cleaning wand, floor tool and upholstery tool. The American Floor Surfacing Machine Co., Dept. MH, 518 S. St. Clair St., Toledo 4, Ohio. (Key No. 67)

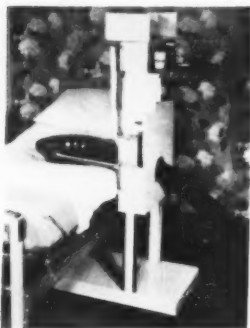
## Color Slide File

A new type file box has been designed especially for filing miniature black and white and color transparencies. A simple, practical file, the unit consists of 12 compartments hinged together in such a way that they form a complete file box when closed. The compartments are open along the top and sides but will easily hold from 1 to 20 cardboard slides or up to 8 glass-mounted slides each. Any compartment of the file may be swung out from the base of the box, thus making all slides instantly and conveniently accessible. An



index sheet is provided on the inside of the cover. Eastman Kodak Co., Dept. MH, Rochester 4, N.Y. (Key No. 68)

### Bedside Toilet Care



Practically a portable, miniature bathroom, the Lavoilet, combining lavatory and flushing toilet, has flexible rubber hose plumbing connections so that it serves the bedridden patient. When not in use, the Lavoilet is pushed back out of the way. When needed, it is wheeled over to the patient's bed where the toilet section is fitted over the bed for use, then the unit is swung around and the lavatory is available.

The handling of bedpans is eliminated through use of the Lavoilet which is practical for any patient who can move in bed without difficulty. The flush toilet gives the patient a greater sense of comfort and the nurse is relieved of an arduous duty. The washbasin side of the unit, with hot and cold running water, has a mirror, soap dish and glass holder so that the unit provides literally a private bathroom for the bedridden patient. When not in use and with seat cushions in place, the Lavoilet provides an extra chair. **American Hospital Supply Corp., Dept. MH, Evanston, Ill. (Key No. 69)**

### Plastic Accessories

Doctor's Bootees of plastic, designed to be put on over regular shoes to protect both shoes and trouser legs upwards from plaster of paris during cast work, or in any other kind of operation where such protection would be advantageous, are now available. Made of Krexex, a plastic material which is easily cleaned by wiping with a damp cloth or dipping into light suds, the bootees give full protection to feet and legs and are easily tied over the trouser leg.

Another plastic accessory recently introduced is the new fluoroscopic screen cover, made in two standard sizes, with elastic band in the back to give proper fit and full protection to screens while not in use. These two new items have recently been added to the full line of plastic surgical aprons offered by the company. **Petra Mfg. Co., Dept. MH, 1335 N. Wells, Chicago 10. (Key No. 70)**

### Caster Clip

Castors can now be attached to the bottom of mopping tanks without drilling holes which might develop leaks or rust. A heavy clip, designed to go under the head of each caster-nut and over the bead of the tank, pulls the caster spider against the inner side of the tank flange and rigidly locks it in place. Tanks with the improved casters are now available in 32 and 44 quart sizes as standard. **Geerpres Wringer, Inc., Dept. MH, Muskegon, Mich. (Key No. 71)**

### Replaceable Parts Furniture

Furniture that can have parts replaced when damaged or worn is now available. It is so designed and constructed that in case of damage or wear, any part can be replaced or interchanged as desired. Factory finished dresser tops, ends,



drawer fronts, sides or bottoms can be secured to match the furniture.

The furniture is designed to combine the beauty and richness of wood with the strength and durability of steel. There are no glued joints, sides are of rustproof steel and drawers are constructed to provide the maximum of space. It is available in a choice of four colors. **Wood Steel Products Co., Dept. MH, Kewaunee, Wis. (Key No. 72)**

### Laboratory Oven

A small, low cost vacuum oven has recently been developed for use in small laboratories. It requires a shelf space only 4 inches wide and 7 inches long. The oven has sensitive thermostatic controls and "black heat" heating elements. Uniform temperature is the purpose of the new design and the oven was developed to do, on a small scale, the same work as the standard sized vacuum oven. **National Appliance Co., Dept. MH, Portland 18, Ore. (Key No. 73)**

### Blakeslee Mixers

The new line of Blakeslee mixers has been designed for more efficient operation and the new flowing lines facilitate cleaning. The variable speed control is a feature of the new models. A "V" belt drive permits changing to any speed by a simple turn of a hand wheel while the mixer is in operation. The beaters travel around the bowl as they rotate, thus assuring more even mixing. The new mixers are available in floor and bench models, in sizes ranging from 12 to 80 quart capacity, and they are finished in Duco or stainless clad construction. **G. S. Blakeslee & Co., Dept. MH, 1844 S. Laramie Ave., Chicago 50. (Key No. 74)**

### Aneroid Manometer

The new B-D Jeweled-Bearing Yale Aneroid Manometer employs the watch-making principle of jeweled bearings, thus offering less friction, dependable accuracy, long life and great durability. The new manometer features uniformly spaced scale graduations for greater visibility, long-travel beryllium copper bellows and rugged construction to stand bumps and jolts of ordinary handling. It is attractively designed in a shape which is easy to hold and handle and is available in either black or surgical gray.

As a companion to the B-D Yale Aneroid Manometer, the new B-D Security Cuff offers fast, easy application and provides even pressure without bulging or herniation. The cuff has 20 adjustments.

The new aneroid manometer may be detached from the inflation system by a twist of its Luer slip connection to the tubing, thus permitting rapid deflation. One instrument may be used with several cuffs in clinic practice and the aneroid may be used in cuffs of different sizes. The manometer and the Security Cuff, hook-type, are supplied in a black



pigskin pocket pouch with snap lock. **Becton, Dickinson & Co., Dept. MH, Rutherford, N.J. (Key No. 75)**

### "Krene" Plastic Draperies

"Krene" plastic is a completely waterproof material which does not mildew, crack, rot or peel. Draperies made of this material are now available and offer attractive, practical hangings for patients' rooms, dormitories, reception rooms and elsewhere in the hospital. The variety of colors and patterns and the attractive appearance of these draperies make them esthetically satisfying. On the other hand, they are practical and economical, both in original cost and in maintenance, since they can be washed in the laundry or wiped clean at the window, require no ironing and are crush-resistant, flame-resistant and fade-resistant. **National Carbon Co., Inc., Dept. MH, 30 E. 42nd St., New York 17. (Key No. 76)**

### Calgonite Control

The Calgonite Control is designed to maintain automatically any required concentration of Calgonite compound in washing equipment. The result of intensive field and laboratory work, the control has a variable resistor which permits adjustment of the feed of solution to the wash tank for any soil load or any desired concentration of the washing compound and automatically and continuously measures the strength of the washing solution. The unit operates on 110 V 50-60 cycle alternating current and is wired into the starting switch of the washing machine. It may be operated by a separate switch if the operator prefers. **Calgon, Inc., Dept. MH, 323 Fourth Ave., Pittsburgh 22, Pa. (Key No. 77)**

### Campbell Bed Lamp

The Campbell Adjustable Bed Lamp is designed to be clamped to the moving head section of any standard hospital spring. In this way it is always available to provide light at the right place, for doctor's examination or treatment or for patient's convenience, regardless of the



elevation of the head section.

The light is fully adjustable through flexible joints at both top and bottom.

permitting focusing in any desired position. When turned upward, it serves effectively as a night light. **Campbell & Co., Dept. MH, 918 Race St., Cincinnati 2, Ohio. (Key No. 78)**

### Insecticidal Paint

Years of research and field tests have gone into the production of two interior paints, a flat paint and a gloss enamel, with insecticidal properties. Formulated for durability, serviceability and ease of application as well as for maximum toxicity to insects, the paints are of high quality and are said to ensure control over all common insect pests for a matter of years. DDT is incorporated directly into the oil-base paints and in this form is claimed to be lethal to flies, mosquitoes, roaches, gnats and other insects. **Sonoco Products Co., Dept. MH, Hartsville, S. C. (Key No. 79)**

### "Grantham" Tumbler



The Hoffman "Grantham" Tumbler is an automatic unloading tumbler designed to dry completely 200 pound loads of rough dry work in 15 minutes and to pre-dry the same poundage of flatwork in less than 5 minutes. Designed for institutional use, the new tumbler has a reversing cylinder 72 inches in diameter. The new design, resembling somewhat that of an open end tumbler, automatic control and radiant gas heating are features of the new tumbler which help reduce floor space and labor cost.

The unloading operation with the new machine is said to take about 30 seconds and to be free of hand pulling. Loading can also be accomplished rapidly since the design of the 40 inch circular door permits loads from a centrifugal extractor to be pushed directly into the cylinder. Automatic operation is controlled by a single lever which automatically closes the door and starts the tumbler. **United States Hoffman Machinery Corp., Dept. MH, 105 Fourth Ave., New York 3, N.Y. (Key No. 80)**

### Electrical Grounding



A device designed to combat static electricity hazards in hospital operating rooms by effectively grounding the surgical team in the operating suite, is now available. Known as No Stat, the device provides body-to-floor contact by a circlet worn on the leg or around the waist with a connecting bead-chain and a floor contact button built into an adjustable shoe clamp.

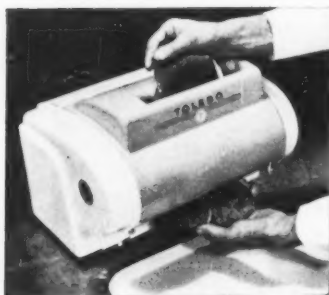
The device is easy to put on or take off and is designed to maintain positive electrical contact between the person and a conductive floor, thus causing excess currents to pass off harmlessly to the ground. No Stat is worn over uniforms or other clothing and it is equally convenient for men and women personnel. **Walter G. Legge Co., Inc., Dept. MH, 101 Park Ave., New York 17. (Key No. 81)**

### Boned Turkey

Boned turkey is now available in aluminum foil wrapped rolls under the name Tur-King. Utilizing all parts of the turkey meat with the exception of the neck, wing tips, liver, heart and gizzard, Tur-King is pressed into a long cylindrical package and wrapped in pure aluminum sheeting before being quick frozen. When ready to be used, Tur-King is cooked in the wrapper, thus reducing shrinkage during cooking and improving the flavor. The aluminum coating can be punctured, after cooking, to release juices for making gravy and for other purposes.

Turkey in this new form eliminates work and waste, has no bones and can be stored with a considerable saving of space. After roasting it can be served hot or cold, thick or thin, as dinner meat or in sandwiches, for salads, creamed dishes and in other variations. The product is the result of long research and should prove invaluable in hospital dietary planning. Tur-King was developed by **Norbest Turkey Growers Assn., Dept. MH, 212 Utah Oil Bldg., Salt Lake City 11, Utah. (Key No. 82)**

### Toledo Steak Machine



Flavorful but inexpensive cuts of meat can be made into tender, nutritious steaks with the new Toledo Steak Machine. The action of the cutting rolls knits odd pieces and trimmings of meat into steak portions and will blend different meats to increase menu variety. An automatic safety clutch protects motor and cutting area by stopping the machine in case bones or other hard substances are accidentally fed into it.

The machine is modern in design with white and gray baked enamel cover which is easy to keep clean. The entire cutting assembly can be removed as a unit for cleaning and all parts contacting meat are of stainless steel. The machine is powered by a 1/3 h.p. motor and is driven by helical cut gears that are sealed in oil. **Toledo Scale Co., Dept. MH, Toledo 12, Ohio. (Key No. 83)**

### Business Machines

Those responsible for the supervision of business machines will be interested in the new equipment recently announced by IBM. In addition to the newly designed machines, the company announces that the IBM executive electric typewriter is now available with a new fabric ribbon designed to give a sharper, cleaner impression.

The new products announced include an accounting machine with wheel printing which accumulates and lists information from IBM cards; a new card punch of increased efficiency and ease of operation; a card-programmed electronic calculator embodying developments from the construction of large IBM calculators for pure and applied science; an electronic collator which handles cards punched with codes and other designations of materials; a device which permits the use of IBM cards in the automatic operation of the IBM electric typewriter; an electronic statistical machine combining the various functions of preparing statistical information; an improved proof machine for sorting and listing checks, slips and similar documents, and a time recorder of increased flexibility and improved functioning. All

the new machines are the result of research and engineering development and are of the high quality and sturdy construction of all IBM equipment. **International Business Machines Corp., Dept. MH, 590 Madison Ave., New York 22. (Key No. 84)**

### Hot Beverage Server

Coffee, tea, chocolate and other hot beverages can be served piping hot on each tray with the new Harvey Pattern beverage server recently introduced. Made of metal in a most attractive design, with spout and handle, and with the temperature maintenance built into the server, the new model is available in chrome or silver plate. It is easy to keep clean, has a stainless steel inside lining and is 7 inches high. The new server keeps liquids at desired temperatures for a reasonable serving period.



thus permitting a hot second serving at the patient's convenience. **Stanley Div., Landers, Frary & Clark, Dept. MH, New Britain, Conn. (Key No. 85)**

### Dishwashing Detergent

China, glass, silver, aluminum and plasticware are easily and effectively washed with Chat, a new liquid organic detergent containing Dry-A-Pon. Designed for use in mechanical dishwashing, Chat permits dishes and glassware to dry without water spots as Dry-A-Pon lowers surface tension of water, causing it to drain off in sheets instead of in droplets.

Chat mixes with water instantly and uniformly, has high wetting, dispersing and emulsifying powers, and eliminates hard water deposits on dishware and on washing machines. Only a small quantity is needed in the washing water for fast, clean drying, thus making it economical in use. It is available in 5 gallon cans and in 29 and 53 gallon drums. **Parker D. Perry Inc., Dept. MH, 729 Boylston St., Boston 16, Mass. (Key No. 86)**

### Protective Wall Coating

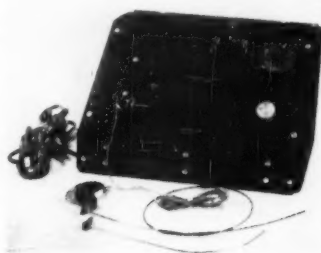
Mental hospitals and general hospitals requiring seclusion rooms for disturbed patients will be interested in "Cush-N-Wall," the protective, cushion coating for all surfaces of the seclusion room, which cannot be cut, torn or otherwise mutilated. It removes physical dangers from the room and eliminates the necessity for restraint apparatus.

Made of Firestone Foamex covered with a strong fabric, which is sprayed with a specially-prepared coating which is air cured, the cushioning results in a wall that is resilient, tough, flame-resistant and sanitary. It provides insulation and soundproofing when the material is installed in the room. A bed built into the room and covered with the same material and a specially designed opening for viewing the patient complete the details of the room. **Porter Bldg. Equipment Co., Dept. MH, 6505 Euclid Ave., Cleveland 3, Ohio. (Key No. 87)**

### Rauh Electronic Locator

Foreign material within the body can now be located during surgery through use of the new Rauh Electronic Locator. Consisting of a sensitive electromagnetic transducer, a high gain amplifier and a loud speaker which is on the amplifier panel, the device can be used to locate gall stones, kidney stones and foreign bodies. Probes of various types are obtainable which permit investigation of the common duct and other areas for gall stones, of the ureter for stones and other obstructions, and of various parts of the body for locating glass or pieces of metal which are imbedded in the tissues.

Probes are instantly interchangeable. A different sound is produced by contact with stone, scar tissue, metal and other materials. The transducer and probes may be autoclaved, boiled or cold sterilized. The Electronic Locator operates by plugging into a 110 volt 60 cycle current. The machine was developed by



**F. M. Rauh & Company and is distributed by Edward Weck & Co., Inc., Dept. MH, 135 Johnson St., Brooklyn 1, N.Y. (Key No. 88)**

## Pharmaceuticals

### Ointment Bacitracin

Ointment Bacitracin for topical application in the treatment of a number of infectious processes is indicated for direct application to the involved area one or more times daily, depending upon the severity of the infection. In the treatment of external ocular infections, Ophthalmic Ointment Bacitracin should be applied directly to the infected structure. Both ointments contain 500 units per Gm. Ointment Bacitracin is supplied in 1/2 ounce collapsible tubes and Ophthalmic Ointment Bacitracin in 1/4 ounce collapsible tubes. Eli Lilly & Co., Dept. MH, Indianapolis 6, Ind. (Key No. 89)

### Somagen

Somagen is a protein preparation of high biologic value, indicated as a source of protein or as a dietary supplement. A palatable mixture of milk proteins and yeast and liver concentrates, Somagen may be taken in dry form or with milk or water added. It is supplied in 1 pound bottles. The Upjohn Company, Dept. MH, Kalamazoo 99, Mich. (Key No. 90)

### Flo-Cillin Aqueous

Flo-Cillin Aqueous is a suspension of crystalline procaine penicillin G containing 300,000 units per cc. It is stable at room temperature for a period of 1 year and is ready for immediate injection without the addition of diluents of any kind. It is indicated in all conditions where a parenteral form of penicillin is indicated, and gives therapeutically effective blood concentrations for a period of 24 hours or more following the injection of 1 cc. It is supplied in single injection kits with a B-D disposable plastic syringe, and in 10 cc. vials. Bristol Laboratories Inc., Dept. MH, Syracuse 1, N. Y. (Key No. 91)

### Suppository Package

An unusual and practical new package has been developed for Ozetts (Oilzo Suppositories). Designed to keep suppositories, formulated to break down at body temperature, in perfect condition during exposure to high temperatures in shipping and storage, the new container is a 2 piece plastic box which duplicates the mold used in forming the suppositories. When kept refrigerated, the suppositories may be easily removed for administration by lifting the strip of cellophane in the package. The manufacturer has obtained a design patent on the container which will be used for other suppositories in the line. The G. F. Harvey Co., Dept. MH, Saratoga Springs, N. Y. (Key No. 92)

## Product Literature

• An attractive gray booklet, tied in red ribbon, each copy especially prepared for the individual hospital, explains "The X-4 Charm Plan" which is described as "A new, effective and dignified method for the raising of funds to purchase one or more Armstrong X-4 Baby Incubators for your hospital." Service organizations, hospital auxiliaries, and other groups will find this method of purchasing Armstrong X-4 Baby Incubators for their institutions a simple, interesting procedure. And you will enjoy reading the presentation of the idea as it appears in the "Plan" folder, one of which will be especially prepared for your hospital, on request, by The Gordon Armstrong Company, Inc., 1501 Euclid Avenue, Cleveland 15, Ohio. (Key No. 93)

• "Fractures, A Motion Picture," is the title of a booklet illustrated in full color which describes the new 16 mm. educational motion picture entitled "Fractures: An Introduction." The film was produced for the American College of Surgeons by Eddie Albert Productions, Inc., under a grant from the Johnson & Johnson Research Foundation. It may be obtained without charge by any hospital in the United States desirous of using it for instructional purposes in the teaching of undergraduate and graduate nurses, interns, residents and other personnel by writing Orthopedic Products Div., Johnson & Johnson, New Brunswick, N. J. The film is in full color with sound and the booklet describing it uses illustrations from the film. This is the first of a series of films on fractures, designed to illustrate the elements of pathology and repair, the basic principles of treatment and certain standard technical procedures. (Key No. 94)

• Hospital heating and air conditioning control systems are described in a booklet recently issued by Minneapolis-Honeywell Regulator Co., 2820 Fourth Ave., S., Minneapolis 8, Minn. The booklet describes in non-technical terms the various atmospheric requirements of hospital rooms and other areas and discusses a number of fuel-saving heating control systems which may be installed in existing buildings as well as in new buildings. (Key No. 95)

• A revised instruction booklet, Bulletin 812A, "How to Install and Operate Your Durcopump," has been issued by The Duriron Company, Inc., Dayton 1, Ohio. Data on the installation and operation of centrifugal pumps in corrosive service with information on proper location of pumps, proper foundations for pumps, common troubles and how to overcome them and other details are given in this bulletin which is printed on varnished, smudge-proof paper. (Key No. 96)

• Hospital administrators, architects, building-equipment committees and others looking for the right type of flooring for various rooms and departments in the institution will find helpful information in the new 8 page catalog of "Tile-Tex Products, Floors and Walls for Today's Hospitals" recently issued by The Tile-Tex Division, Chicago Heights, Ill. In addition to information on Tile-Tex asphalt tile floors, Tuff-Tex unit-laid greaseproof floors, Flexchrome plastic tile floors, Mura-Tex plastic tile walls, Tile-Tex asphalt cove base and Tile-Tex maintenance products, all items attractively illustrated in typical installations, the catalog gives brief standard specification data on Tile-Tex products. (Key No. 97)

• Proper procedure for intravenous infusion is illustrated in the new filmstrip, "1,000 cc. 5% Dextrose i.v.," available from Cutter Laboratories, Berkeley 1, Calif. The 35 mm. black and white filmstrip, complete with detailed captions for standard nursing procedure courses, shows the recommended step-by-step technic for administration of solutions by the intravenous route and illustrates the manufacturing processes used to produce sterile, pyrogen-free solutions. The filmstrip runs for 15 minutes and hospital sequences were photographed at Alameda County Highland Hospital, Oakland, Calif. (Key No. 98)

• Catalog T-4 on "Blickman-Built Food Conveyors" contains helpful information for the administrator and his dietary department. Details of the new seamless top which eliminates crevices in food conveyors, thus permitting higher standards of sanitation, details of the selective menu food conveyors which provide facilities for selective menus and special diets, the 14 features which make these conveyors efficient and sanitary, general specifications and data on other Blickman-Built units for dietary service make the catalog a valuable source of information. It is published by S. Blickman, Inc., Weehawken, N.J. (Key No. 99)

• "Tennant Floor Treating Materials" are discussed in a 2 color leaflet issued by G. H. Tennant Co., 2530 N. Second, Minneapolis 11, Minn. Characteristics and uses of Tennant floor seals, waxes and special-purpose materials are given together with a comparative chart of self-polishing waxes. (Key No. 100)

• A complete compilation of excerpts of writings on aerosol therapy from 1939 through 1948 is offered in a 182 page plastic bound booklet entitled "Vaponefrin Aerosol Library." The book has been published by the Vaponefrin Company, Upper Darby, Pa., and is offered at the publishing cost of \$2.50 per copy. (Key No. 101)

## Book Announcements

The Blakiston Company, 1012 Walnut St., Philadelphia 5, Pa. New Gould Medical Dictionary, compiled by group of editors, 252 illus., 129 in color, 1st ed., (Key No. 102)

W. B. Saunders Co., W. Washington Square, Philadelphia 5, Pa. Clark, Nash and Fischer, "Quantitative Chemical Analysis," 448 pp., \$4.25. (Key No. 103)

The Williams & Wilkins Co., Mt. Royal & Guilford Aves., Baltimore 2, Md.

Stedman's Medical Dictionary, 17th Ed., 1405 pp., \$8.50. (Key No. 104)

## Suppliers' News

Commercial Solvents Corporation, 17 E. 42nd St., New York 17, announces the opening of new laboratories and research center at Terre Haute, Ind. A large portion of the new facilities will be devoted to studies of antibiotics and other pharmaceuticals.

Everest & Jennings Co., 761 N. Highland Ave., Los Angeles 38, Calif., manu-

facturer of folding wheel chairs, folding aluminum crutches and wheel chair accessories, announces acquisition of a new plant, adjacent to the present facilities, which will almost double its manufacturing floor space.

General Electric X-Ray Corp. announces change of street name. Instead of McGeech Ave., the new address is 4855 W. Electric Ave., Milwaukee 14, Wis.

The stock of Ille Electric Corp., 36-08 33rd St., Long Island City 1, N. Y., manufacturer of hydro-therapeutic equipment, has recently been acquired from the estate of the late Floyd W. Ille by 4 key executives of the corporation. The new owners will continue the business and announce the expansion of the company's research and development program.

The Wm. S. Merrell Co., Cincinnati 15, Ohio, manufacturer of pharmaceutical products, announces the promotion of W. Burl White to the post of Hospital Sales Manager.

O.E.M. Corporation, East Norwalk, Conn., manufacturer of oxygen equipment, announces the acceptance by Underwriters' Laboratories, Inc., of its Mechanair iceless oxygen tent.

Peirce Wire Recorder Corp., 1328 Sherman Ave., Evanston, Ill., manufacturer of wire dictation systems, announces election of R. J. Rountree as Vice-President of the company in charge of sales and advertising.

Thomas J. Rudesill, widely known in the hospital field through his association with Scanlan-Morris Co. and later as manager of Scanlan-Morris sales for The Ohio Chemical & Mfg. Co., 1400 E. Washington Ave., Madison 10, Wis., as well as for his active interest in Hospital Industries Association, died of a heart ailment on October 30 at Madison, Wis.

E. H. Sargent & Co., manufacturer and distributor of scientific laboratory instruments, apparatus and chemicals, announces removal of its offices and plant to a new and modern building at 4647 W. Foster Ave., Chicago 30.

Stokely-Van Camp, Inc., Indianapolis, Ind., food distributors, announces formation of the Institutional Food Department in charge of F. D. Neilson, a newly formed division to serve hospitals, colleges and other institutional food needs.

Vulcan-Hart Mfg. Co., Bayard & Hamburg Sts., Baltimore 30, Md., is the new name of the firm manufacturing Vulcan Gas Cooking equipment, the line having been purchased last July from the Standard Gas Equipment Corp.

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Bessie Covert  
Editor, "What's New for Hospitals"

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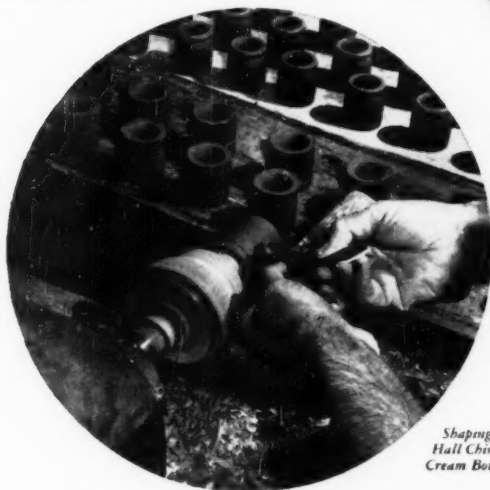
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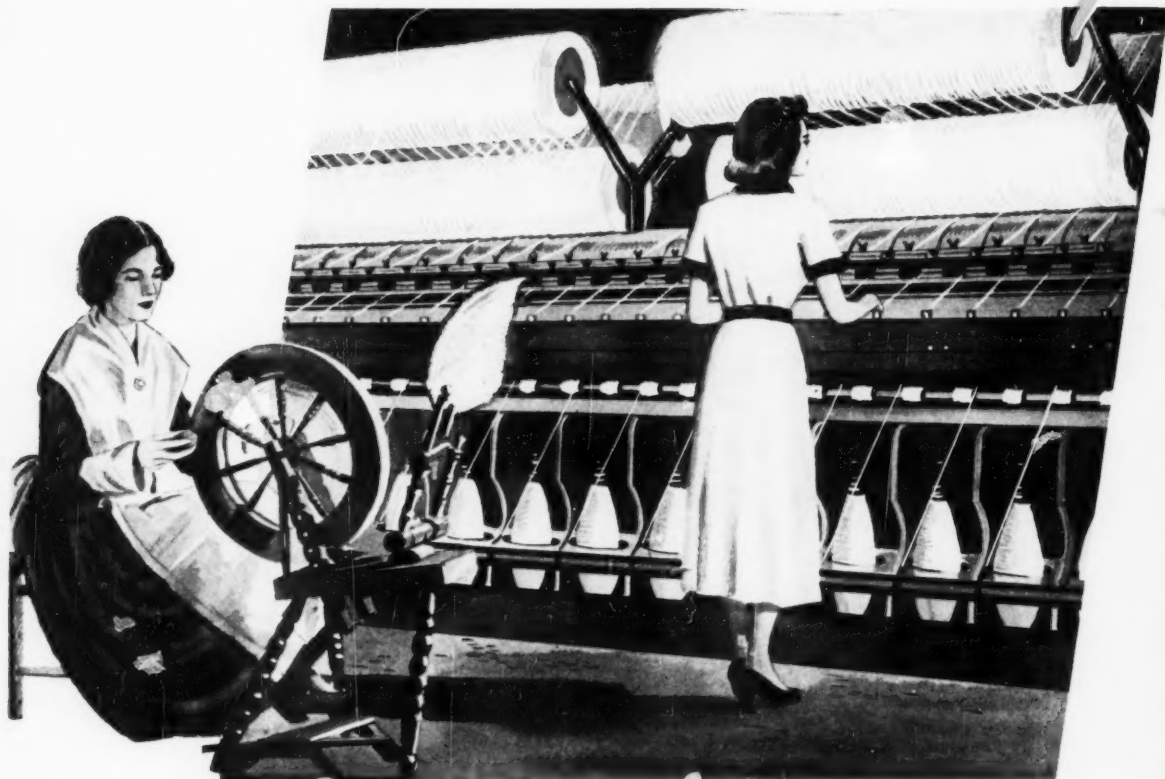


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